Mapping therapeutic services for sexual abuse in the UK in 2015

Prepared for the National Society for the Prevention of Cruelty to Children (NSPCC)

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EXECUTIVE SUMMARY

About the mapping exercise

1. *The International Centre: Researching Child Sexual Exploitation, Trafficking and Violence* at the University of Bedfordshire was commissioned by the National Society for the Prevention of Cruelty to Children (NSPCC) to undertake a mapping exercise – across England, Wales, Scotland and Northern Ireland - of therapeutic services for children and young people who have experienced any form of child sexual abuse (CSA), including child sexual exploitation (CSE). This mapping exercise was intended to be an update, and facilitate a comparative analysis with the 2007 audit. However, different samples and the more limited nature of the exercise means that it is inadvisable to make direct comparisons. However, the current mapping exercise has revealed new insights about a broader range of services than were included in the previous 2007 audit.

2. The current mapping exercise consisted of: 1) identification of generalist and specialist services in the four nations providing therapeutic support for any form of child sexual abuse, including child sexual exploitation (n=750); 2) an online questionnaire distributed to all identified services; 3) a small number of follow-up telephone interviews with service providers and 4) a small number of telephone interviews with service commissioners. A total of 130 respondents provided data in the questionnaire on 149 services, giving a service response rate of 20%.

Key findings

There were a range of findings across funding and commissioning experiences of services, provision for children and young people, current service use and met and unmet need among the sample. Key findings include:

- Obtaining full and accurate data on current service use is complex and difficult, and the task has not improved since the 2007 audit where similar difficulties were encountered. A key recommendation in that report was an improvement in the recording of data, particularly by services such as Child and Adolescent Mental Health Services (CAMHs) but the evidence suggests this has not been addressed. This makes it incredibly difficult to establish solid evidence about the need/demand for services and whether or not current provision is adequately meeting the demand.

- Some of the generalist services in the current mapping exercise were unable to provide referral figures on CSA/CSE because they do not tend to disaggregate their figures on this particular issue.
- The referral data provided in the current mapping exercise shows an overall gap (a 12% current gap and an anticipated gap of 17% in future) in provision across the services in this sample to children and young people who have experienced child sexual abuse / exploitation. While some children may be referred to other services, there are likely to be some children who do not receive a service, or do not receive a timely service.
- The mapping exercise revealed a large number of services across the UK comprised of both specialist and generalist services which exist across statutory, voluntary and private sectors and in some case comprise multi-agency initiatives.
- Whilst specialist services have been identified by some commentators to be more responsive and tailored to victims of sexual violence, it is clear that in the current climate of increasing awareness and demand, generalist services are identifying and supporting children and young people who have experienced CSA / CSE.
- Despite variation in the needs and support required between younger children and older children who have experienced CSA/ CSE, some services are supporting both groups. What is less clear is whether these services are effectively equipped to provide specialised support to meet the needs of children and young people experiencing different forms of CSA.
- SARCs have been an important development in provision of streamlined support for victims of sexual violence, although a key finding identified both in the literature and within this mapping exercise is a lack of emotional support within these services for children and young people who have experienced child sexual abuse / exploitation.
- Since the 2007 audit, there appears to have been little change in the funding environment for CSA. Greater awareness of CSE means that it is possible that there has been more attention given to funding specialist services in this area at the expense of services dedicated to other forms of CSA.
- Across specialist services, funding continues to be provided through insecure and short-term funding cycles which are at odds with the nature of the provision required to adequately support children and young people with these experiences. Services continue to devote an enormous amount of time and energy to chasing new funding streams, which, they say diverts energy and time away from delivering quality services to children and young people.

- Service providers and commissioners have noted how complex and confusing the commissioning environment is, creating more stress and insecurity for providers.
- Service providers feel confident that they will continue to be funded but this confidence derives primarily from an optimism about their reputations and the current high priority of CSA/CSE rather than having actually secured future funding.
- Some referral sources for services are more developed than others; only 50% of services are seeing/accepting referrals from the police, for example and fewer from youth justice and youth services.
- CAMHs remain difficult to access and the situation appears to be declining in some areas in the face of funding cuts in recent years. Providers view CAMHs as largely difficult to access, a finding which has been identified in other studies and reviews of services.
- Almost all services, however, set eligibility criteria to restrict access. Age is one of the more common criteria and the mapping exercise has shown that, at least among the current sample, services for younger children are scarce while services for older children and adolescents are in somewhat greater supply.
- Although there is significant variability in the quality and amount of referral data received, the patterns of service provision suggest that it is White British girls without disabilities who comprise the largest group receiving services.
- Creative therapies remain a common approach in working with children and young people who have experienced sexual abuse. The 'therapeutic relationship' is also very common across services which focus on child sexual exploitation as well as other forms of child sexual abuse.
- Services are largely only accessible during the hours of 9 to 5 during the weekdays. For children and young people who may want and need support outside of these hours, provision is scarce.
- Children and young people with eating disorders, substance abuse problems, additional mental health needs and young offenders are most likely to be referred onwards to another service for help.

Although originally intended to facilitate comparative analysis with the 2007 audit, the fact that the 2015 and 2007 samples had negligible overlap (only two services participated in both studies) means this has not been possible. The inadvisability of direct comparison between the two studies is compounded by the different inclusion criteria (see Chapter Two) and the different datasets collated in each study. Some broad observations, can however, be offered on the findings of both studies. Patterns of referral by demographic data in 2015, though highly variable, do show similarities to the patterns observed in 2007. For example, more girls received services than boys;

most children and young people who received services were White British; few had disabilities; more children age 10 to 15 received services than any other age group. Provision characteristics are also broadly similar between the two samples with creative therapies most common, followed by counselling and CBT. Social workers were the most common source of referral in both samples. Waiting lists, in both samples, were estimated by services to be three months on average although some services had waiting lists of up to and over a year. Respondents across both studies reported that they were operating within an insecure and short-term funding environment (with a greater number of services reporting an absence of indefinite funding in the current sample) which diverts energy away from the provision of quality services to children and young people.

Priority recommendations

There are three priority recommendations which have emerged from this mapping exercise. These can be summarised as 1) the need for better data on referrals; 2) the need for comprehensive support for children and young people; and 3) the need for a more stable and less complex commissioning and funding process.

1. **Recommendation 1:** The government should establish good and robust data on referrals for child sexual abuse. This could take the form of a central repository for referral data to be regularly submitted for the purposes of better understanding need and demand in the context of actual provision. All services (specialist and generalist) which support children and young people therapeutically should be recording CSA and CSE as a matter of course. In particular, generalist services should begin to record this information as it would assist in providing an accurate reflection of their work where they are encountering children and young people with these experiences. This would also enhance the national picture of demand experienced by services. Evidence from this mapping exercise, in concert with evidence from the 2007 audit, other research and consultation with experts suggest that CAMHs should also include classifications of sexual abuse in their initial assessments. This information should be recorded as a matter of course in order to improve assessment of need within the service, but also nationally.

2. **Recommendation 2:** Given the central government recognition of CSA/CSE as a 'national threat' and in the context of clearly evidenced increases in reporting, the government have a duty to ensure there is adequate provision for children and young people who have experienced sexual violence.

3. **Recommendation 3**: Government should look at ways of providing more secure funding for services delivering therapeutic support to children and young people who have experienced CSA (or are at risk of experiencing CSA). Doing so would ensure that these children and young people receive timely, adequate and un-interrupted therapeutic support to move on from their experiences. Funding bodies should look for ways of reducing the complexity and increasing the transparency of the commissioning and funding process. This would aid in reducing the workload and stress of already pressurised services and allow services to focus on the business of supporting children and young people.

Areas for further investigation

In addition to priority recommendations, there are a number of areas requiring further research and investigation, either because the limited nature of the current mapping exercise meant these areas could not be fully examined or because the mapping exercise revealed insights that raise further questions. These areas include the following:

A) While it is widely believed that specialist services are best placed to deliver specialist therapeutic support for victims of sexual violence, evidence from this mapping exercise suggests that generalist services are encountering children and young people who have experienced CSE and other forms of CSA. Not only that, but there is evidence to suggest they are now actively looking for these experiences given the high priority of CSA/CSE. Whether or not generalist services should be providing this support, the evidence is that they are. Specialist and generalist services, therefore, should have the right training and skills in place to deliver appropriate support. Further research is needed into the experiences of generalist services in identifying and supporting these children and young people.

B) Investigation is required into the best way to provide emotional support to children and young people who have experienced CSA/CSE. Given that SARCs are intended to provide a streamlined service for victims of sexual abuse / assault, it is important to further examine whether they should be providing emotional support as well or whether it is more appropriate for these services to refer children onwards.

C) Health, education and the police have a key role to play in identifying victims of violence and abuse, in providing early intervention for those at low and medium risk and in referring on to relevant specialist services. These

agencies should identify and develop better links and relationships with all local, relevant support services.

D) More research is needed about provision for younger children experiencing intra-familial CSA. Adequate provision is required under international frameworks and at present, there appears to be greater attention aimed at services for older children.

E) More research is required to better understand why some service user groups continue to be under-represented in referrals to services and among those who receive services.

F) More research is required to establish a better evidence base for current approaches to working with children and young people who have experienced sexual abuse.

G) Service provision is largely delivered during office hours to children and young people. Further investigation is required as to why services are not offering support outside of these times, given that sexual violence can occur any time and that emotional support may be required at unconventional times.

H) While services report being able to work with children and young people who have a wide variety of needs, there are still some children with complex needs who require additional support. Further investigation is needed about the ways in which services are doing this, in order to understand whether a gap exists for children with complex and particular needs.

1 Introduction, background and context

1.1 Background to the mapping exercise

In 2007, as part of the Rebuilding Childhoods campaign, the National Society for the Prevention of Cruelty to Children (NSPCC) undertook the first mapping exercise of therapeutic child sexual abuse (CSA) services in the United Kingdom, with the final report published in 2009 (Allnock et al., 2009; Bunting et al., 2009; this will be referred to as the 2007 audit hereafter). The audit was intended to provide a national context of therapeutic support for children and young people who have experienced sexual abuse and was part of a longer term programme of work culminating in the development, by the NSPCC, of a new child-centred therapeutic service for children and young people (Allnock and Hynes, 2011).

The 2007 audit found significant gaps in provision across all four nations, identifying a conservative shortfall of 55,794 therapeutic places for children and young people who needed or wanted a service (Allnock et al., 2009). Several other mapping exercises carried out prior to 2010, albeit focussed on young people with sexually harmful behaviour and sexual violence services for women, supported the 2007 audit finding that specialised provision for sexual violence overall was patchy and under-funded (Hackett et al., 2005; Coy et al., 2007).

Since the 2007 audit, there have been significant shifts in political and social attention to CSA and, in light of this, the NSPCC wanted to understand the current landscape of provision. To this end, they commissioned the research team to design, distribute and analyse a self-completion survey (and undertake a number of telephone interviews with service providers and commissioners) to:

a) Map the range and extent of therapeutic services across the four nations (England, Wales, Northern Ireland and Scotland) which support children and young people who have experienced child sexual abuse/exploitation (or who are at risk of sexual exploitation) and
b) Estimate the gap between need for services and actual provision, using the best available data.

Although developed with similar overall objectives to the 2007 study, this project was more limited in scope in terms of timing, resources and – relatedly - depth of information requested of survey respondents. It should not therefore be considered to be a repeat of the 2007 audit, nor directly comparable with it.

1.2 Changes in the social and political landscape

CSA has historically been neglected as a subject of political and social importance, only gaining wider public recognition in the 1980s. While better recognised politically and socially since then (and during the time of the 2007 audit), it has not garnered the kind of recognition that, for example, domestic violence has in the last several decades. However, media reports of widespread abuse carried out by the late Jimmy Savile in 2011 brought the issue squarely into the public consciousness, and as a result, Operation Yewtree was established and investigations remain on-going (Gray and Watt, 2013). This was followed by emerging reports of widespread sexual exploitation of children and young people in a number of British cities, bringing child sexual exploitation (CSE) as a particular form of CSA into the public spotlight (see, for example, Jay, 2014; Coffey, 2014).

The Government subsequently gave CSA the status of a national threat in the Strategic Policing Requirement in March of this year to ensure it is a priority in every force in England and Wales, with a commitment to establish a cross-governmental national centre of expertise on CSA announced at the same time (HM Government 2015). The Independent Inquiry into Child Sexual Abuse (also known as the Goddard Inquiry) was launched on the 9th of July, 2015 to investigate whether public bodies and other non-state institutions have taken seriously their duty of care to protect children from sexual abuse in England and Wales. Historical Abuse Inquiries are also either underway or planned in Northern Ireland (Historical Abuse Inquiry, n.d.) and Scotland (Scottish Executive, n.d.). The Police in England and Wales have also initiated Operation Hydrant, a coordinating structure for multiple historical CSA investigations around the country. The Children's Commissioner for England has been carrying out an inquiry into intra-familial sexual abuse with interim findings to be released later in 2015.

Given this extensive activity in the field, both historical and recent, the problem of CSA is unlikely to fall off the political agenda or disappear from the public consciousness any time soon. The activity – including the media attention around it - is already having significant impact on the reporting of both historical and recent CSA (see section 1.4 on prevalence).

1.3 Definitions

The English government definitions of CSA and CSE have guided this work. Similar to the definition applied in the other three nations, these state that CSA:

> *Involves forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening. The activities may involve physical contact, including assault by penetration (for example, rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing. They may also include non-contact activities, such as involving children in looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse (including via the internet). Sexual abuse is not solely perpetrated by adult males. Women can also commit acts of sexual abuse, as can other children* (Department of Education, 2015, p. 93).

Child sexual exploitation is recognised as a specific form of child sexual abuse, defined as follows:

> *Sexual exploitation of children and young people under 18 involves exploitative situations, contexts and relationships where young people (or a third person or persons) receive 'something' (e.g. food, accommodation, drugs, alcohol, cigarettes, affection, gifts, money) as a result of them performing, and/or another or others performing on them, sexual activities* (DCSF, 2009; p. 9)

Although CSE is recognised as a form of CSA, the unique 'exchange' dynamics of CSE and the fact that it predominantly affects older children who frequently do not see themselves as victims mean that therapeutic work with those at risk of, or experiencing, CSE may need to be approached very differently to younger children or those who have experienced intra-familial abuse[1] or extra-familial abuse where specific CSE dynamics are not present. Therefore, although it is somewhat artificial to divide CSA and CSE, for the purposes of this report on service provision, and on the basis of how services self-defined in the questionnaire, some services will be referred to as CSE specialist services, some will be referred to as specialist services for other forms of CSA (excluding CSE) and some services will be referred to as specialist services for all forms of CSA.

[1] This is not to say that CSE cannot take place within the family, although evidence suggests that most identified cases occur outside of this environment.

1.4 Prevalence

At the time of the 2007 audit, only one national prevalence study of abuse and maltreatment had been carried out in the United Kingdom (Cawson et al., 2000). That study reported that 11% of young people aged 18 to 24 had experienced contact sexual abuse in their lifetime. Since then, a new prevalence study has been published by the NSPCC (Radford et al 2011). Box 1a below presents some of the headline figures from this study.

Box 1a: Headline figures related to CSA (Radford et al 2011)

1) 24.1% of 18 to 24 year olds reported that they had experienced CSA under the age of 18 (this may include contact or non-contact sexual abuse, perpetrated by any adult or peer)
2) 12.5% of 18 to 24 year olds reported that they had experienced contact CSA under the age of 18, perpetrated by any adult or peer) (generally comparable to the previous study's findings)
3) 2.1% of 11 to 17 year olds said they had experienced sexual abuse by an adult or peer in the last year (this may include contact or non-contact sexual abuse)
4) 0.2% of under 11s (as reported by parents/carers who responded to the survey on their behalf) experienced sexual abuse by an adult or peer in the last year (this may include contact or non-contact sexual abuse)

Figures that establish the extent of CSE are more difficult to obtain, as there have been no nationally representative studies that have considered all forms of CSE – either on- or off-line. Figures for CSE, then (see Box 1b), have been gathered from a number of sources to provide a rather incomplete picture of the extent of the problem across the UK. Figures on CSE from studies asking young people about their experiences (in other words, self-report data) are generally higher than figures gathered from official sources. No separate figures have been found for the scale of CSE in Scotland (for example, see Brodie and Pearce, 2012), although several of the figures in the box below present a 'national UK picture' and thus the findings are the best available across the four nations.

Box 1b: Headline figures related to CSE

1) 16,500 children in England at very high risk of sexual exploitation by gangs or groups/ 2,409 confirmed victims of sexual exploitation in gangs and groups in 2010/2011 (Berelowitz et al 2012)
2) 2,083 children and young people in the UK believed to have been groomed and/or sexually exploited in 13 Local Children Safeguarding Board (LSCB areas) / 1,875 cases identified in areas with pro-active intelligence gathering and multi-agency work (CEOP, 2011)
3) 2,120 lone perpetrators involved in suspected or confirmed CSE cases in 25 police forces in England and Wales; 65 group and gang offences in 31 police forces/ 1,145 reports of online CSE received by CEOP (CEOP, 2013)
4) 2,092 known victims of CSE identified by 70 LSCBs in England (48% return rate)/ 5,669 children at risk of sexual exploitation identified by 79 LSCBs (54% return rate) / Number of victims identified by similar authorities ranged from 66.54 to 1 per 10,000 children and young people (OCC, 2013)
5) 184 separate cases of children and young people who were identified as being sexually exploited or at risk of being sexually exploited were found across 20 of 21 local authorities in Wales in 2008 (Coles, 2005)
6) 367 separate cases of mostly at-risk (of CSE) children and young people were identified in 2008 in one ACPC area in Wales (Clutton and Coles, 2007)
7) Social workers in Northern Ireland identified CSE to be an issue of concern for 1 in 7 young people aged 12 to 17 with whom they work (Beckett, 2011)
8) One in nine 16 year olds in Northern Ireland (11%) reported being groomed for sexual purposes by an adult, whether or not anything sexual happened (Beckett and Schubotz, 2014)

It continues to be recognised by experts that cases of CSA/CSE remain under-reported and under-identified, but at present, these figures are the best available. While it is difficult to establish whether or not CSA/CSE is increasing, there is compelling evidence that the reporting (to the police or another statutory agency) and recording of CSA/CSE is increasing across all four nations. While a considerable proportion of the increase is related to historical abuse cases (in other words, people who are now adults reporting abuse from their childhood), there is data to suggest that more children and young people under the age of 18 are being identified or are reporting. Box 1c provides headline figures on these trends.

Box 1c: Headline figures related to increased reporting of CSA/CSE

1) Between 2009/10 to 2013/14, the number of child rape offences reported to the police in England and Wales increased by 37%, from 5,674 in 2009/10 to 7,775 in 2013/14. This equates to an increase from 53 to 72 per 100,000 child population (Rape Monitoring Group, 2014)
2) There were 22,294 recorded sexual offences against children under 16 in 2013/14 in England (excluding offences that include victims up to the age of 18 – abuse of a position of trust and abuse of children through prostitution and pornography). This equates to a rate of reported sexual offending against under 16s in 2013/14 of 2.2 per 1,000 children. This represents an increase of 26% from the previous year (Jütte et al., 2015).
3) There were 1,485 recorded sexual offences against children aged under 18 in 2013/14 in Northern Ireland, a rate of 3.4 reported sexual offences per 1,000 children under 18. This also represents an increase of 26% from 2012/2013 (Jütte et al., 2015).
4) Scotland also recorded the highest number of sexual offences against children in 2013/2014 in the past decade. There were 3,742 recorded sexual offences against children under 18 in 2013/14 in Scotland (3,101 excluding offences that include victims up to the age of 18). This is a rate of 3.4 sexual offences per 1,000 children under 16 (Jütte et al., 2015)
5) There were 1,502 recorded offences against children under 18 in 2013/14 in Wales (1,478 excluding offences that include victims up to the age of 18 – abuse of a position of trust and abuse of children through prostitution and pornography). This is a rate of 2.7 sexual offences per 1,000 children under 16). The number of recorded sexual offences against children under 16 has increased significantly in Wales from 818 in 2004/2005 to 1,478 in 2013/2014 (See Jütte et al., 2015).

Support services are also reporting increased levels of referrals and help seeking behaviours. For example, the NSPCC annual report *How Safe are our Children*, published in May 2015, reported a rising trend in sexual abuse/online sexual abuse concerns from calls to Childline; this was the highest abuse-related main concern in 2014/15. Childline carried out 11,839 counselling sessions over the past year with children whose main concern was sexual abuse/online sexual abuse.

In addition, Rape Crisis collates annual data provided by their membership of fifty autonomous Rape Crisis services across England and Wales. Their unpublished

statistics reveal that over 50,000 individual sexual violence survivors (13% for whom age was known, were under 18) received ongoing (i.e. more than one session) services from Rape Crisis in 2013 - 2014. This represents an increase of over 50% of self-referrals between the years 2012 - 2013 and 2013 -2014. In addition, Rape Crisis services received and responded to 165,000 helpline calls across the network in 2013 - 2014. This represents a 27% increase on calls received and responded to since 2012 – 2013, although it is not known how much of this increase was represented by under 18s.

1.5 Updated policy context

This section details key legislative, policy and guidance frameworks in place in relation to the *support* of victims of all forms of CSA. It is not the intention to be exhaustive of all activity around CSA, as there has been considerable debate and attention to issues such as prevention and protection since the 2007 audit. However the frameworks mentioned all have relevance to the support of victims of CSA. Readers may refer to the 2007 audit (Allnock et al., 2009) for detail on policy and legislation in place at the time the audit was carried out.

International frameworks such as the United Nations Convention on the Rights of the Child (UNCRC) remain relevant across all nations. In particular, Article 39 (Rehabilitation of child victims) states that: *Children who have been neglected, abused or exploited should receive special help to physically and psychologically recover and reintegrate into society. Particular attention should be paid to restoring the health, self-respect and dignity of the child.* This international framework is more important than ever in the context of increasing demand and as signatory to the convention, the government of the United Kingdom (UK) (and its devolved nations) has an obligation to ensure the realisation of this critical right.

England

The Children Act 1989 and the Children Act 2004 still remain the central pieces of legislation guiding child protection in England. An updated version of the statutory guidance *Working Together to Safeguard Children* (Department for Education, 2015) details the responsibilities of agencies in cooperating to safeguard and promote the welfare of children. Since the 2007 audit, however, CSE – as a form of CSA – has been explicitly recognised through the publication, in 2009, of supplementary guidance to the *Working together to safeguard children* guidance (DCSF, 2009). The purpose of this guidance is to support local agencies in their application of the core guidance (*Working Together*) in the specialist area of CSE. The first ever National Action Plan – *Tackling child sexual exploitation* – was also published in 2011

(Department for Education, 2011), with a specific section recognising the need for counselling and on-going support for CSE victims. Currently, there is no specific crime of sexual exploitation. Offenders are instead convicted for associated offences such as sexual activity with a child (Berelowitz et al., 2012). The most recent activity in relation to CSE is detailed in a recent government policy paper *Tackling child sexual exploitation* (HM Government, 2015). Support for victims of CSE was recognised through the commitment of £7 million as a source of funding for support services. While CSE has been a particular focus of government attention in recent years, the Children's Commissioner is due to report on an Inquiry into sexual abuse in the family by the end of 2015. Additionally, an inquiry into historical sexual abuse is now underway and due to end in 2020 (See section 1.2 above).

The coalition government policy on *Violence against Women and Girls* details what the government is doing in respect of sexual violence more broadly, which includes all forms of child sexual abuse (Home Office, 2015). The current policy expires this year – 2015. However, there are a number of key activities which have formed the basis of this policy between 2010 and 2015, including, briefly: 1) the development of a national working group on Sexual Violence against Children and Vulnerable People to prevent sexual abuse and improve criminal justice responses to it; 2) the government commitment to nearly 40£ million in funding for sexual violence support services, although this funding is coming to an end this year (2015); 3) the government part-funded 87 independent sexual violence advisers; 4) more than £1 million has been committed to specialist rape support organisations across England and Wales as part of the first ever fund to help male victims of rape and sexual violence.

Wales

CSE and other forms of CSA in Wales fall within the responsibility of the Social Services and Integration Directorate as well as overlapping in some respects with the Violence Against Women and Domestic Abuse Act 2015 (Violence Against Women and Domestic Abuse Act, 2015). All Wales Safeguarding children and young people at Risk of Sexual Exploitation Protocol (2008) (All Wales Child Protection Group and Welsh Assembly Government) was developed in response to the findings of the Welsh Assembly Government funded review of existing CSE protocols (2006). The protocol is intended to support the identification of children and young people at risk of CSE and to ensure that there is consistent evidence based practice across Wales in responding to risk and abuse through CSE so that children and young people are safeguarded. The protocol also outlines the holistic response required and recognises that investment is needed for long-term intervention.

Since then, supplementary guidance on CSE was released in 2013, which explicitly refers to the support of victims of CSE (or those at risk of CSE) (Welsh Assembly Government, 2013). This year the Welsh Government have committed to producing a Wales CSE Action Plan with a task group currently consulting on this (NSPCC 2015a).

Northern Ireland

Since the 2007 audit, there have been some structural changes regarding child protection responsibilities in Northern Ireland. In 2012 the Safeguarding Board for Northern Ireland was established, which replaced and assumed the functions of its legacy body, the Regional Child Protection Committee (RCPC), the key objective being to determine the strategy for safeguarding children and to develop and disseminate policies and procedures. The SBNI has an extended role to include the wider area of safeguarding as well as statutory child protection and is the key process for agreeing how children's agencies will cooperate to safeguard and promote the welfare of children in Northern Ireland. NSPCC is named in the SBNI legislation (The Safeguarding Board Act (NI) 2011) as a core member of the Board. One of the five local safeguarding panels established within the SBNI holds responsibility for development of policies and procedures.

The Department of Health, Social Services and Public Safety (DHSSPS) recently consulted on new 'Co-operating to Safeguard Children' guidance which will replace the guidance issued in 2003 and a number of amendments have been proposed, including a change to the definition of CSA. DHSSPS and the Department of Justice also recently consulted on a new joint strategy for addressing domestic and sexual violence and abuse in Northern Ireland ('Stopping Domestic and Sexual Violence and Abuse in Northern Ireland 2013-2018'). Consultation closed in April 2015; and a final version of the strategy has not yet been released. A regional Sexual Assault Referral Centre (SARC) was established in 2013, jointly funded by DHSSPS and PSNI – providing support to children and young people and adults.

Regarding CSE, following a Police Service of Northern Ireland investigation (Operation Owl) focusing on a number of children and young people mostly from care settings relating to allegations of sexual exploitation, a thematic review of 22 CSE cases was commissioned by DHSSPS as well as an independent inquiry into CSE (Marshall, 2014). The inquiry focused on both children at home in the community and also those living in care. The thematic review of the 22 cases was

undertaken by researchers at Queen's University Belfast, and final publication is still outstanding.

Scotland

The Children and Young People (Scotland) Act 2014 legislates for core components of the 'GIRFEC' approach (Getting it right for every child), effectively creating new systems to support children and identify problems – or wellbeing concerns - at an early stage, long before a child reaches crisis point. Specifically it legislates for the Named Person role – the central role in the GIRFEC approach - requiring every young person aged up to 18 to have a 'named person' (consisting of different professionals at different developmental stages), that is a key person who anyone can approach if they have concerns about a child's wellbeing. The National Guidance on Child Protection was refreshed in 2014 and includes a specific section on CSE (the Scottish Government, 2014a). Scotland also has a National Action Plan on CSE, a key strand of which recognises the need to support victims (the Scottish Government, 2014b).

Scotland is also engaging with Violence against women and girls through the *Equally Safe* strategy (Scottish Government, 2014c). The strategy expanded the strategic approach to domestic abuse to become an overarching approach to address all violence against women and girls. A key strand is the provision of a robust and effective response to women and girls as well as perpetrators. However there are currently questions around the strategy because it did not directly address the issue of CSE, and arguably CSA, in a strategy aimed at addressing all gender based violence against women and girls (NSPCC, 2015).

The Human Trafficking and Exploitation (Scotland) Bill, currently at stage two, has implications for CSE, and the proposals will enhance the status of and support for victims of trafficking.

1.6 Structure of the report

This is a UK-wide study covering England, Wales, Northern Ireland and Scotland. The data in this report is aggregated to give an overall picture across all four nations. However, hyperlinks allow the reader to move to detailed data tables by country and other relevant characteristics in the Annex. The data for some nations (particularly Wales and Northern Ireland) is very limited, and therefore it is important to note that the results should not be generalised to all services, in all nations.

Chapter two briefly describes the method used in this mapping exercise and includes an overview of the sample. Chapter three explores sources and length of funding as well as service provider confidence in future funding. Chapter four describes pathways into services, eligibility criteria and waiting lists, and presents data on current service use. Chapter five examines what it is that children and young people receive once they have been accepted after referral, including models/approaches to therapeutic/emotional support, availability of the service and provision for children and young people with particular needs. Chapter six presents data which describe the current unmet need as reported by service providers.

Each section includes a reflection on and summary of key findings and the report concludes with relevant policy and practice recommendations. Quantitative data from the survey provides the overall internal structure of the sections, and qualitative data from open-ended questions in the survey and telephone interviews is interwoven where relevant to elaborate on specific issues.

2 Methodology

This Chapter provides an overview of the methodology used for the current mapping exercise, which was a limited follow-on study of the 2007 audit. In brief, the research team compiled a list of services which provide therapeutic support for children and young people who have experienced – or who are at risk of experiencing – CSA/CSE. A questionnaire was distributed to all identified services believed to be eligible for this mapping exercise. A small number of telephone interviews were also undertaken with service providers and commissioners to obtain additional qualitative data on service provision.

2.1 Inclusion criteria for services

The current mapping exercise allowed service providers to 'self-define' as a therapeutic service for children and young people, and was open to any specialist services for children and young people who have experienced CSA, including children and young people who have experienced – or are at risk of experiencing – CSE. The mapping exercise was also open to generalist services in both the statutory and voluntary sector. The 2007 audit took a similar approach but focussed primarily on forms of CSA excluding CSE, and was limited to generalist services in the health sector, or, in other words, Child and Adolescent Mental Health services as generalist services. Box 2a below illustrates the range of services which were eligible for the present mapping exercise.

Box 2a: Types of services identified and included in the mapping exercise

To be eligible, services had to provide face-to-face support. Telephone or internet-only support services were not included on this occasion.

Specialist services for child sexual exploitation (or at risk of CSE) only/ other forms of child sexual abuse (excluding CSE)/ and services which therapeutically support children who have experienced any form of CSA. These could be voluntary, statutory or private sector services or part of a multi-agency initiative. They could be large or small services. They could be services which support children only or children and adults.

Generalist services. These are services which support children and young people for any issues affecting their well-being; sexual abuse or exploitation may be part of that. As long as these services provide support for these children (as opposed to referring children who disclose CSA/CSE onward), they were included. These could also be voluntary, statutory, private or multi-agency. They could be large or small services and could be services which support children only or children and adults.

2.2 Identification of services for the mapping exercise

Although CSA has been identified as a national priority, there is no national list of services working in this field. Therefore, the research team spent considerable effort identifying and contacting relevant services to whom to distribute the questionnaire. The original database of services from the 2007 audit was initially consulted and details of those services updated. The Survivor's Trust, as an umbrella organisation of sexual violence services, was consulted and cross-checked with the developing list. Other online directories such as Youth Well-being, Family Support Northern Ireland, Survivor's Scotland and the Directory and Book Services (DABS) directory were consulted and checked against the list. A systematic search of the Internet was also undertaken, utilising Local Authority names and key terms. Policy and research contacts in all four nations were consulted for additional services. The research team attempted contact with all services identified to confirm service details.

The questionnaire included a request to service providers to identify any other local support services, and responses were checked daily during the course of data collection to ensure all new services identified received an invite to participate in the questionnaire. Finally, the mapping exercise was advertised by the NSPCC CASPAR service, the National Working Group (NWG), the International Centre at the University of Bedfordshire and via the ChiMat[2].

Table 2a presents the breakdown of services which the research team identified, by country and sector: 750 services were identified as potential service providers supporting children and young people who have experienced CSE or other forms of CSA. The research team identified a greater sample of services potentially providing this type of support compared with the sample identified by the 2007 audit, which identified 508 services.[3] This is largely due to the explicit inclusion of CSE services, more Rape Crisis services, the SARCs, and generalist services across the voluntary sector.

Table 2a Total number of services identified for the audit (n=750)

	Statutory	Voluntary	Private	Total

[2] ChiMat is the newsletter for the National Child and Maternal Health Intelligence Network which will be received/read by at least some CAMH services, see www.chimat.org.uk

[3] A proportion of these services may have been ineligible for the study, but it is not possible to know because the research team were unable to make direct contact with some services to confirm provision.

England	268	283	25	576
Wales	6	13	5	24
Northern Ireland	32	28	0	60
Scotland	41	49	0	90
Total	347	373	30	750

Some changes in service provision from the 2007 audit were evident in the identification phase of the present mapping exercise. Sexual Assault Referral Centres (SARCs), for example, were not fully established in 2007, and, at the time, the research team found that they were largely delivering services to adults. Currently, however, there are SARCs in almost every police constabulary and services are provided to children (variably) from the age of 12 upwards. Rape Crisis Centres were also in patchier existence in 2007 than at the present time, as the Map of Gaps 2007 revealed (Coy et al., 2007).

Identifying and making contact with statutory services was difficult. There were considerable challenges involved in contacting and engaging CAMHs. No central listing of CAMH services could be found despite our best effort; this was confirmed by other mental health services, the Department of Health and the Programme Manager of CAMHs. Furthermore, most CAMH providers can only be contacted via telephone, and given the time restrictions and resources for the work, it was impossible to call each and every service. A number of methods were used to reach as many CAMH services as possible including:

1) The Programme Manager for CAMHs distributed the link to the questionnaire through the network of Children and Young People – Improving Access to Psychological Therapies (CYP-IAPT) collaborations, and this was likely to have reached just over 100 CAMH services as not all are yet partnered with the collaborations.
2) The few CAMH providers who advertise an email address were also sent the link to the questionnaire
3) The NSPCC provided additional staff for a short period of time to call CAMH services.

However, despite this, the response rate from CAMHs was negligible (although higher than in the 2007 audit). The researchers experienced similar problems making contact and engaging CAMHs providers in the 2007 audit and clearly, the hurdles faced then have not improved in the intervening years.

Inevitably there are some limitations in the nature of mapping studies of this sort. While the research team did their best to identify all services of relevance, it is likely that some services were missed. Directories are only as good as the process for updating them; many rely on voluntary submissions from service providers and thus may not be fully accurate. Smaller organisations may not know or hear about directories; and resources may prohibit them from having a website to find.

A useful observation can be made, however, from the difficulties experienced by the team in finding services for children and young people who have experienced CSA/CSE. If researchers struggle to find these services even with a dedicated resource and systematic approach, it is likely that professionals and children and young people themselves will also have difficulties finding them.

2.3 Data tools and collection[4]

The questionnaire used in the current mapping exercise was a shortened and streamlined on-line version of the postal/email questionnaire that was used in the 2007 audit. The link to the questionnaire was disseminated to all identified services for completion between April 15th and June 9th, 2015. The link was also advertised via numerous websites and in some cases, sent individually to service providers. The questionnaire contained both closed and open-ended questions and was analysed in SPSS version 21 and NVivo 10. The types of data collected include:

- Characteristics of services such as sector, specialist or generalist and country location
- Funding sources, length/ stability of funding, confidence in obtaining future funding
- Referral into services, including sources of referral, waiting times for receiving a service and the numbers of children referred and accepted in the financial year April 1, 2014 to March 31, 2015
- Service provision, including models/ types of support provided, accessibility of services (e.g. times of operation), targeted/special provision for a range of children with particular needs
- Unmet need, including the numbers of children services had been unable to provide a service to, and anticipation of future unmet need.

[4] The 2007 report included Geographical Information System (GIS) maps visually depicting the location of services. This allowed readers to visually identify gaps in provision across the four nations. However, this element was not commissioned for the current mapping exercise.

Follow up interviews were undertaken with 13 service providers and 7 service commissioners during the months of June and August, 2015. Details of their identification, recruitment and selection are provided below.

2.4 Participation and response rate

Questionnaires

A total of 130 service providers partially[5] or fully completed the questionnaire. However, these 130 respondents provided information about a total of 149 services[6]. A majority of respondents (46.5%) were service managers; the remaining respondents varied between therapeutic practitioners, team managers, directors/founders/CEOs, administrators, clinical or counselling leads or operations managers. This is important because some respondents had more or less access to the referral data we requested in the questionnaire, which may partially explain the poor data return within this element of the questionnaire. Table 2b presents the total sample of services providing data, by nation and sector.

Table 2b: Total number of services providing data for the mapping exercise(n=149)

	Statutory	Voluntary	Private	Multi-agency	Total
England	15	88	8	1	112
Wales	1	5	1	0	7
Northern Ireland	0	5	0	0	5
Scotland	4	14	0	0	18
Unknown	0	6	0	1	7
Total	20	118	9	2	149

[5] Only service providers who completed 75% of questions related to their service were included in the analysis. Respondents who completed at least 75% of the questionnaire provided data through the section on referrals - data which was required in order to calculate capacity and under-capacity which is presented in the final chapter of this report

[6] Although 96 respondents completed the full questionnaire, 8 of these respondents 'screened out' at the eligibility stage. Therefore 88 plus 9 partial completers (or 97) service providers were eligible as tracked via Qualtrics software. An additional 33 service providers completed the questionnaire from a link they received via other means. Using 'respondent' as the unit of analysis for calculating the response rate is unreliable however, because one respondent (or service provider) may tell us about more than one service. Therefore, a more reliable response rate is to use 'the service' as the unit of analysis. In this study, we obtained information on 149 out of 750 estimated total services, which means that the present audit had a response rate of 20%.

Interviews

Table 2c lists the service providers and service commissioners who participated in brief telephone interviews. We interviewed a diverse range of providers across the four nations and by service type and sector.

Service providers were recruited via the questionnaire, which included a question at the end asking respondents if they would be willing to be re-contacted for a short interview. The providers were selected from those who agreed to be re-contacted to represent a range of different types of services (for example, specialist and generalist and specialist providers for CSE or other forms of CSA) across different sectors and nations. They were contacted via email which included an information sheet and invitation to take part in a telephone interview. Those who agreed were sent a consent form in advance of the interview to review, and asked to provide their consent over the phone. Eighteen service providers offered to participate and we conducted 13 individual interviews in total.

Service providers who took part in these interviews were asked to nominate and facilitate contact with service commissioners. The commissioners were sent an information sheet via email and were invited to take part in a telephone interview. Those who agreed were sent a consent form in advance and consent was taken verbally on the phone at the time of interview. We invited a total of 31 commissioners to participate in the telephone interviews. Thirteen replied to our request and of these, we interviewed 7. Four of these were individual interviews and one focus group was carried out, comprised of three commissioners.

The interviews lasted approximately 30 minutes, and providers were asked a series of questions from a semi-structured interview guide, designed to help participants to elaborate on their provision. Commissioners were also asked questions from a semi-structured interview guide about their commissioning processes, changes to commissioning in recent years and challenges to commissioning. These telephone-based interviews were recorded and transcribed, then analysed thematically in NVivo 10 software.

Table 2c: Telephone interview participants (n=20)

Sector	Service type	Focus of provision	Country
Service providers			
Voluntary	Specialist	CSA	England
Voluntary	Specialist	CSE	England
Voluntary	Specialist Rape Crisis Service	SV[7]	England
Voluntary	Specialist SARC	SV	England
Voluntary	Specialist		England
Voluntary	Specialist		England
Statutory	Generic	-	England
Statutory	Generic	-	England
Voluntary	Generic	-	Northern Ireland
Voluntary	Specialist	CSE	Northern Ireland
Voluntary	Specialist	SHB[8]	Wales
Voluntary	Generic	-	Wales
Voluntary	Generic	-	Scotland
Service Commissioners			
Statutory			England
Police and Crime Commissioner[9]			England
City Council			England
NHS			Scotland
Ministry of Justice			England

2.5 Overview of the sample

Completed questionnaires were received from 130 service providers, representing 149 services. Although almost half of the service providers to whom the questionnaire was distributed were statutory sector, the majority of respondents came from the voluntary sector. Four fifths of the 149 services represented in questionnaires responses were voluntary sector (n=118, 79.2%); 13.4% (n=20) were statutory, 6% (n=9) were private and two services were part of a multi-agency initiative (see Figure 2c below). Of those services which were statutory (n=20), 11 (55%) were CAMHs; five were social care services; three were 'other health' statutory services (one of these a SARC); and one (a SARC) was a multi-agency initiative

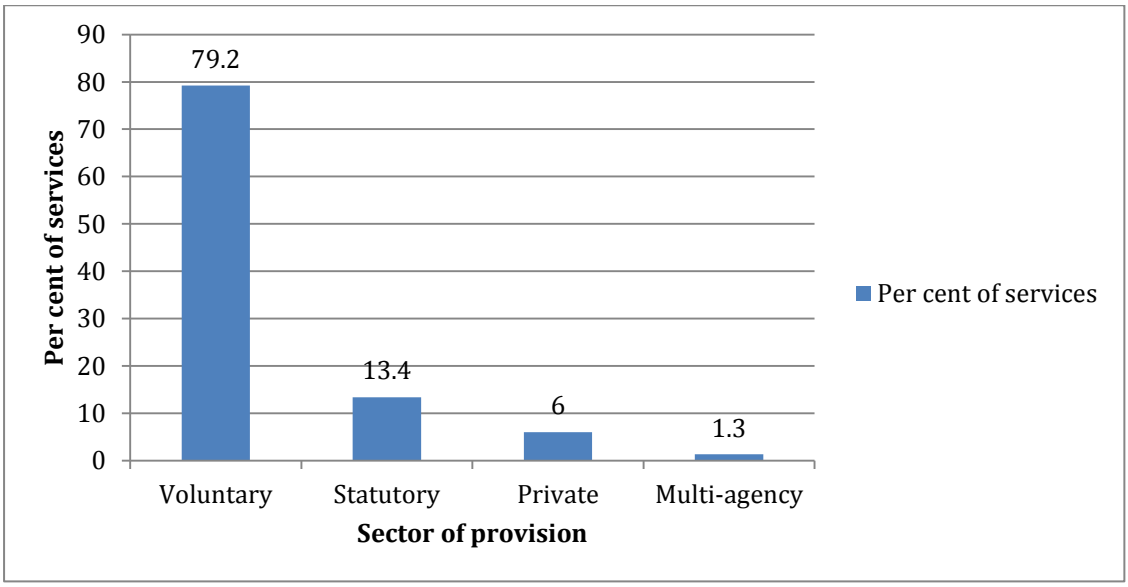
[7] SV refers to services providing support for any type of sexual violence

[8] SHB refers to services providing support for sexually harmful behaviour

[9] Three commissioners were part of a 'telephone focus group' from the Police and Crime Commissioner.

between the National Health Service (NHS) and the Police. A respondent from one additional SARC self-identified the service as private. Four further SARCs screened out[10] on the basis that they do not provide any form of therapeutic work with children and young people. Closer examination of the SARCs which screened in suggest that most (with the exception of one which provides counselling) act as 'hubs' for counselling services rather than provide therapeutic/ emotional support directly; yet they defined their service as 'therapeutic' in and of itself and thus it was decided that the services would remain in the sample.

Figure 2c: Sector of services in the sample, per cent (n=149)



Specialist or generalist services

A majority of the services in the current mapping exercise were self-defined by respondents as 'specialist' providers in CSA and/or CSE (n=97, 65.1%), while the remaining services (n=52, 34.9%) classified themselves as generalist. Table 2d shows, by sector, whether services are specialist or generalist. Click here to see a data table of specialist or generalist services by nation.

[10] At the beginning of the questionnaire, respondents were asked whether they provided any form of therapeutic or emotional support to children and young people. Those who said they did not were screened out of the questionnaire at that stage.

Table 2d Sector services, by specialist or generalist type (n=149)

Sector	Specialist services	Generalist services	Total
Statutory	8 (40%)	12 (60%)	20 (100%)
Voluntary	82 (69.5%)	36 (30.5%)	118 (100%)
Private	5 (55.6%)	4 (44.4%)	9 (100%)
Multi-agency	2 (100%)	0 (0%)	2 (100%)
Total number	97	52	149

Most of the statutory sector services were generalist (60%); of these, three—quarters identified as CAMH services, two were social care and one was an 'other health service'. A majority of the voluntary sector services (69.5%) were specialist services

Ninety-two specialist services specified the group of children and young people they support. Just over half (n= 51; 55.4%) provide a service for children and young people who have experienced any form of CSA; 19 (20.7%) provide a service *only* for children and young people who are at risk of, or are experiencing, CSE; and 22 (23.9%) provide a service *only* for children and young people who have experienced other forms of CSA (excluding CSE). Click here for a breakdown of specialist services by country.

Residential or non-residential services

Almost all the responding providers were non-residential services (n=138 of 147, 93.9%). Click here for a table comparing residential services by sector.

2.6 Ethical considerations

As this was a mapping exercise that could be considered an 'audit' of services and therefore considered 'low risk', National Health Service (NHS) Research Ethics Committee approval was not required. However, ethical approval was sought and received from the NSPCC Research Ethics Committee, the University of Bedfordshire's Institute for Applied Social Research Ethics Committee and the University of Bedfordshire's university-wide Ethics Committee.

The mapping exercise was not considered a sensitive topic and as such was considered low risk, given the focus on service provision. The questionnaire was designed to be anonymous if participants wanted that; but respondents could identify themselves in order to be re-contacted for follow up interviews and to

receive the final report. Only a small number of respondents did not provide their details however, and, to ensure no services were double counted, the research team carefully examined the 'anonymous' responses for any similarities that may suggest that more than one set of data responses came from multiple respondents within the same service. The 'anonymous' services were all services of different types and across the four nations and none appeared to raise any flags regarding double counting. Care was taken to protect confidentiality. The research team adhered to data protection policy and all data – both questionnaire and interview – was held on secure, password protected computers and encryption was used in data transfer.

2.7 Advantages of the current mapping exercise

There is a wealth of valuable information and detail from the participating service providers about the present landscape of service provision. The current mapping exercise has advantages over the 2007 audit in a number of ways:

1) The breadth of services covered in the present mapping exercise is greater.
2) This is the only piece of work in the UK to have examined both CSA and CSE provision simultaneously.
3) It is the only piece of work that has examined the intersection of CSA and CSE specialist services.
4) This is the only piece of work in the UK to have examined CSA and CSE provision within generalist services beyond that of CAMHs.

This mapping exercise also draws attention to the difficulties of obtaining robust information about demand/ need and current service use. More broadly, this work provides a snapshot of funding and commissioning, routes into services, actual provision for children and young people and current service use for a diverse sample of services at the present time.

2.8 Limitations of the current mapping exercise

Aside from the limitations pertaining to identifying services mentioned above, there are also some important methodological limitations to note. Given the problems involved in making contact with statutory services as described above, the majority of the responses came via the voluntary sector. Overall the response rate was low; only 20% (n=149) of services identified provided data. This is a lower response rate than the 2007 audit. However, the data collection period for the 2007 audit was longer (5 months) and fewer services had to be followed up (n=508). In contrast, the

present audit collected data over 6 weeks and identified and attempted contact with around 750 services. A number of explanations could account for the low response rate:

1) the survey link did not make it to the right person (many administrators, for example, would not provide details of the service manager instead saying they would pass the link on);
2) service providers were too busy to give time to the questionnaire (suggested by some providers in an open-ended question in the questionnaire);
3) some service providers like CAMHs do not typically take part in such questionnaires unless they are mandatory (noted by one CAMHs provider in a telephone interview); or
4) the available time to fill out the survey was not sufficient (noted by a small number of managers in emails or on the phone).

A further limitation concerns the overlap between the 2007 audit and the current mapping exercise. Only two services from the 2007 audit participated in the current audit, thus effectively, the two samples are entirely different and any direct comparison of change is, therefore, not possible. It is difficult to speculate on why so few services from the 2007 audit took part in the present mapping exercise. It may simply be explained by some of the reasons listed above, or it could be that those service managers that took part previously have left the service – given that 8 years have passed since the previous one. Any new service manager may not have been aware that the service had been a part of the previous audit. A small number of services (n=10) closed down since 2007 and we could not make contact with them.

These problems constrict any attempts to generalise the data to all services. Further, these problems confounded our ability to calculate the shortfall in services in the same way that was done in the 2007 audit. Additional data collected, however, has allowed for examination of the numbers of eligible children who did not receive a service and thus assess capacity – but within the present sample only.

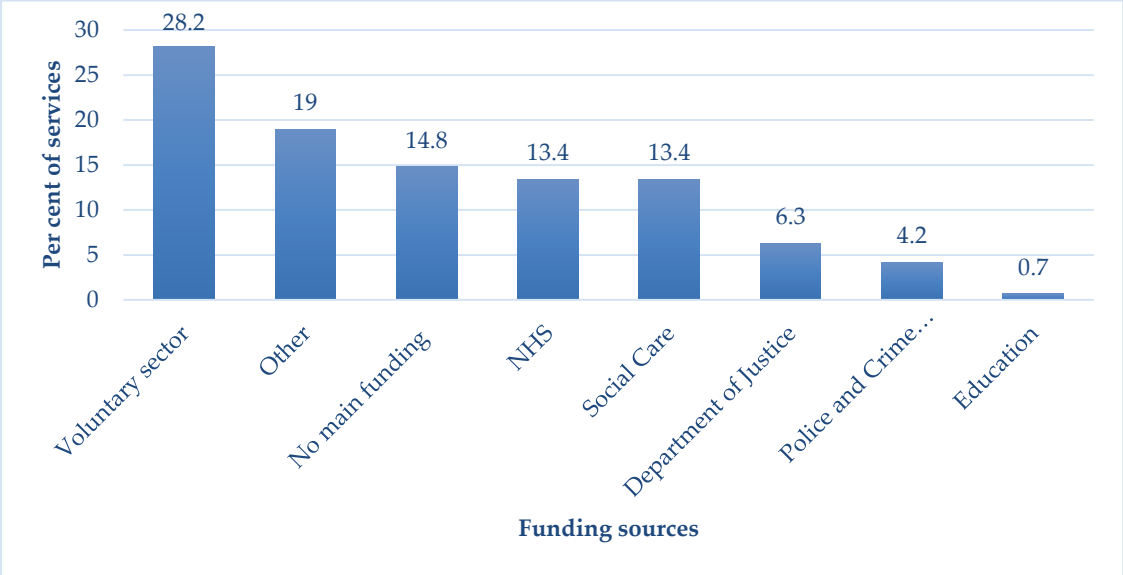
3 Funding and commissioning of services

This chapter reviews data from the questionnaire and short telephone interviews about the funding and commissioning of services for children and young people who have experienced CSA/CSE.

3.1 What is the main source of funding for services?

Although it is recognised that most services will be operating on more than one source of income, we asked respondents to tell us about their 'main' source of funding[11]. Figure 3a illustrates the main sources of funding reported by the current sample.

Figure 3a: Main source of funding, per cent of all services (n=142)



The voluntary sector was reported as the main source of funding for almost one-third of the services in the sample, followed by an 'other source', 'no main funding' and NHS and Social Care at equivalent percentages. Only a small percentage of services are funded by the Department of Justice, a Police and Crime Commissioner or Education. The individual funding bodies listed above may be funding services at higher rates than it appears: some may be funding the services reporting 'multiple streams' of income also but the data available do not allow further analysis of this.

[11] By 'main' source of funding, we meant the source of funding that provides the largest percentage of income to a service. A choice was also provided, however, for a scenario where there are multiple streams of funding where the percentage of income across those streams are more or less equivalent.

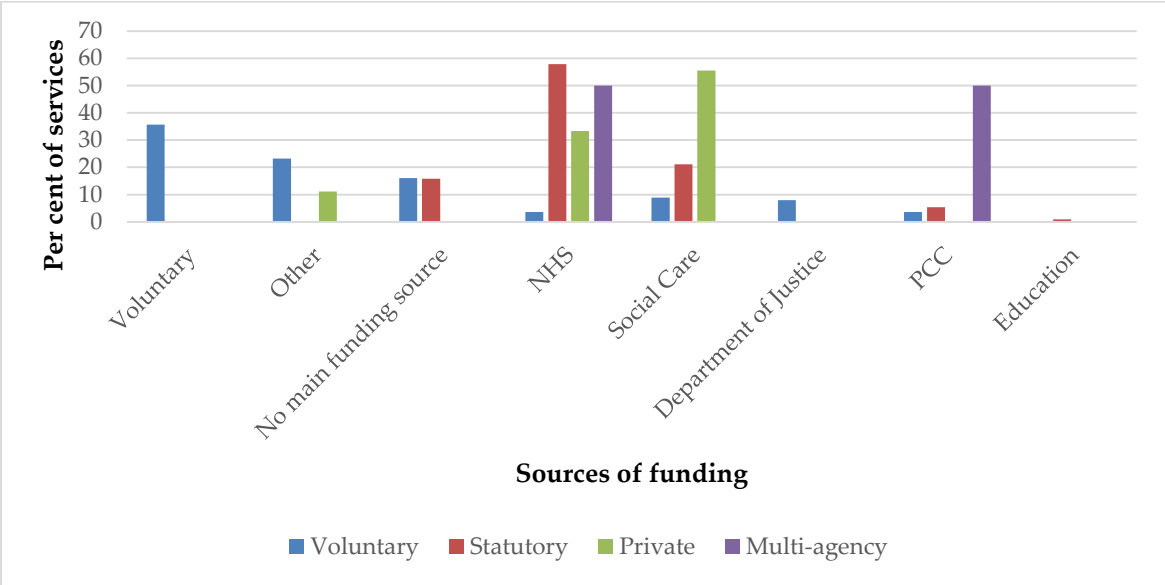
Of those services that reported being funded through an 'other' source, there was additional detail provided for 21 out of 26 services: fundraising/ charitable donations (n=7); Home Office (n=2); The Local Authority (n=1);Young people's service funded by income generated by paying adult clients (n=1); The Department of Health Social Enterprise Investment Fund (n=1); The Scottish Government (n=1); Rape Crisis Specific Fund (n=1); Public Health Agency (n=1); Trust (n=1); Benefactors (n=1); Housing benefit (n=1); Interventions are individually commissioned (spot-purchased) (n=1); London Councils (n=1); unknown (n=1). One service provider reported in an open-ended question that an important change in the last 10 years has been *'the input of big charities like the Big Lottery'* [Statutory generic service, Scotland].

3.2 Main funding, by sector

Figure 3b shows the main source of funding by sector. The voluntary sector services in this sample were the only services to receive funding from voluntary sector funding sources; moreover, among voluntary sector services, the voluntary sector was the most common funding source. 'Other' source of funding was the next most common response for the voluntary sector, followed by 'no main source' of funding. Smaller proportions of voluntary sector services received funding from all other sources except Education.

The greatest proportion of statutory services in this sample were funded by the NHS, however, more than half of the statutory sector services were CAMHs and so this is not surprising. The next most common response for statutory sector services was social care followed by 'no main source' of funding. None of the statutory providers cited 'other' sources of funding, and only small proportions of statutory providers were funded by other sources such as the PCC and Education. Click here for a full data table on funding source by sector.

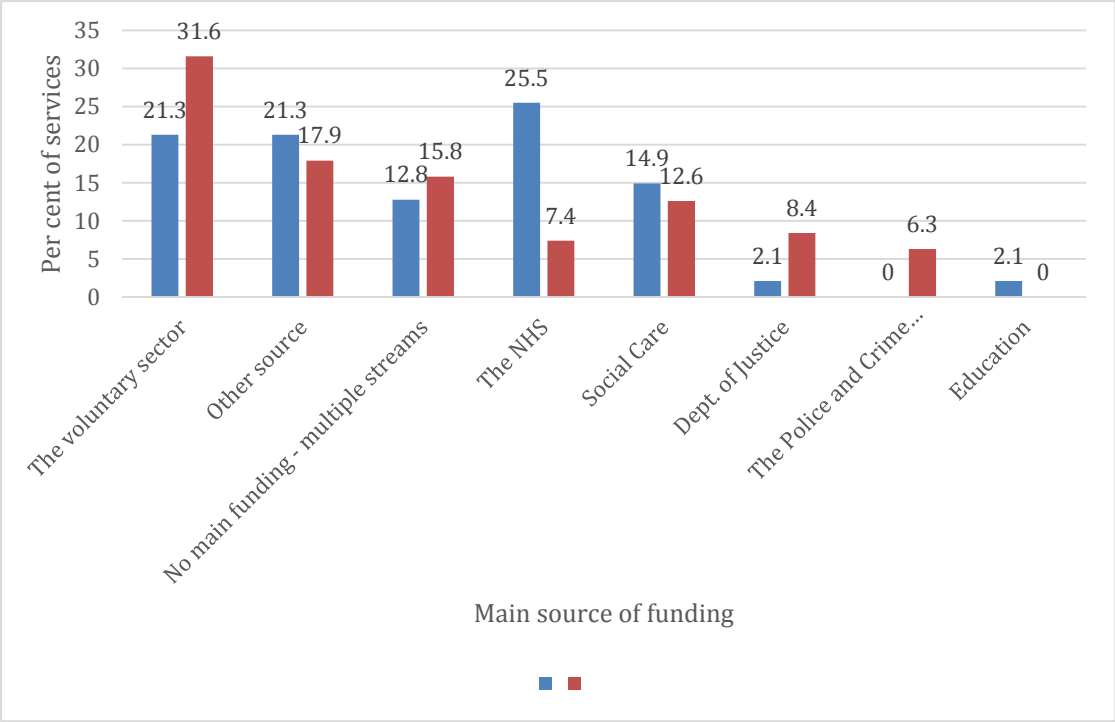
Figure 3b: Main source of funding by sector (n=142)



3.3 Main funding source, by type of service

As Figure 3c shows, the voluntary sector is the single largest source of funding for specialist services in this sample, and a greater proportion of specialist services rely on this funding than generalist services. The NHS is reported as the main source of funding for a much greater proportion of generalist than specialist services; the majority of the generalist services which are funded by the NHS are CAMH services. Only a slightly higher percentage of specialist services report 'no main funding' than generalist services, and a slightly higher percentages of generalist than specialist services are funded by social care. Almost all of the services funded by the DoJ and the PCC are specialist services.

Figure 3c: Main source of funding, by per cent generalist and specialist service (n=142)



Among specialist services, a greater proportion of CSE services report they are funded by the voluntary sector than services for other forms of CSA; a slightly greater proportion of CSE services also report 'no main funding' than services for other forms of CSA. A greater proportion of services for other forms of CSA reported an 'other' funding source than CSE services.

3.4 Length and security of funding

A majority of the services which provided data on funding are not funded indefinitely (n=111 of 137, 81%). Current funding streams for nearly three quarters of the services (n=93 of 137, 67.9%) will end between 2015 and 2020 (52.6% will end in 2015 or 2016). This will partly reflect the end of the £4.4 million funding that was available for some sexual violence services in England, funding 84 Centres (MoJ, 2014) as described in an interview with a Ministry of Justice commissioner. Respondents for an additional 18 services (13% of the total) said they were uncertain about when their funding ends. Of these, three services receive their income through spot purchasing only.

Twenty-six services (19%) are funded 'indefinitely' – one quarter of these are made up of national 'big' charities or rape crisis services[12]. Eleven of these services (or 42.3%) are other voluntary sector services; 11 (42.3%) are statutory services and four services (15.4%) are private. Although the small number of services in some sectors did not allow us to test for statistical differences, the pattern of provision showed that a greater proportion of statutory (61%) and private (50%) services are funded indefinitely than voluntary sector services (10%).

A greater proportion of generalist services in this sample (32.6%) have indefinite funding in comparison to specialist services (12.1%). Of the services who reported that their funding is 'indefinite', 30.8% are funded by the NHS, 34.6% are funded by the voluntary sector, 23% are funded by Social Care and 7.7% are funded by another source that was unspecified. Click here for a data table on length of current funding by country and here for this breakdown by sector.

There was a sense among the commissioners and service providers we interviewed that contracts for specialist provision are too short and that they disadvantage children and young people needing services. While one commissioner described recent positive changes to a length of contract, they acknowledged that it does not work that way for all services and hinted that the complex relationships held with other commissioning bodies can act as a barrier to creating more secure funding for services:

> *I can only speak about the ones I know about, so there used to be annual grant funding year on year, which is very disruptive for both the staff and the service users. So we ran that process last summer and awarded a 3+1 year contract. That's really positive for us, both for the staff and the service users because it's difficult when a rape case can last so long, they [the service] weren't even sure if they would exist to cope with that, for that going to court, so that's really positive for us.*

The commissioner went on to describe the challenges in joint commissioning, in particular how decision-making can be difficult for the organisation who is not the lead commissioner.

Another commissioner lamented about funding connected to current government and priorities:

[12] The services which were indefinitely funded were examined individually to identify what types of services these were. We could determine by the name of the service that one-quarter were large national charities or rape crisis services.

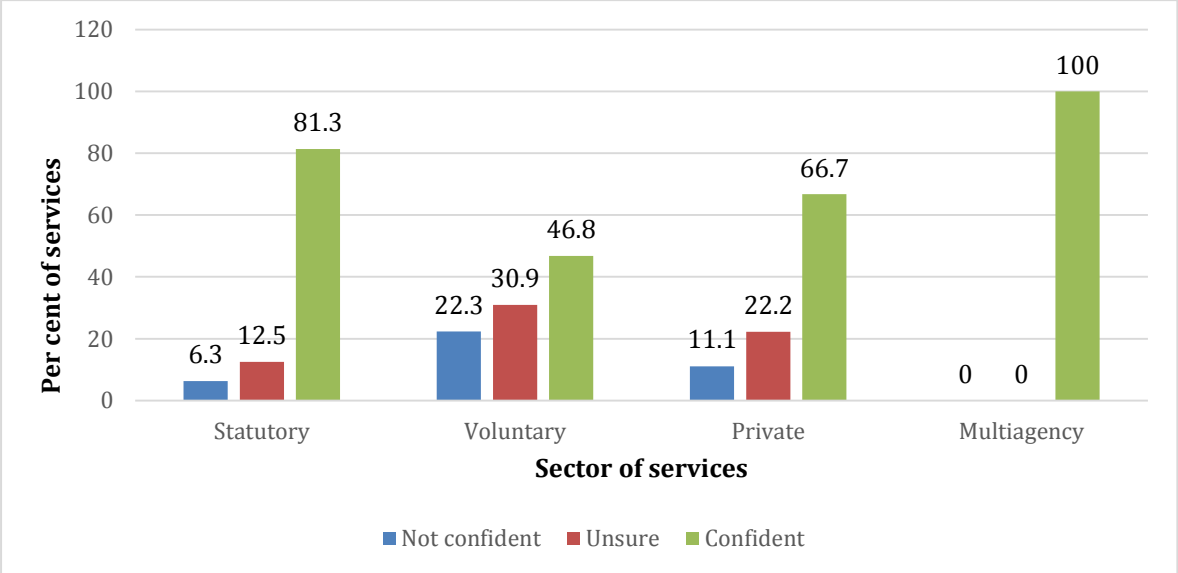
The biggest challenge for the organisation is that it's such a short period of time. We don't know what our funding situation will be. Having commissioning linked to government terms means that there's only so much they (providers) can do. Permanent contracts are tricky when the funding will run out in 2 years time.

3.5 How confident are service providers that their funding will continue?

Respondents were asked to report in a closed-ended question how confident they felt that their service would continue to receive funding after their current round of funding ends. Interestingly, respondents were fairly confident about this; but additional opportunity provided by open-ended questions exploring the challenges services face, revealed a rather different story. These potentially contradictory messages are explored below.

Overall, respondents for 53.7% of services (65 services of 121 who answered this question) expressed confidence that their service would continue to receive funding after their current round of funding ends. A further 27% (n=33 of 121) felt 'unsure', and just under one-fifth (19%) reported that they were not confident. Click here for a data table showing level of confidence in funding by country.

Figure 3d: Service providers' confidence about future funding, by sector, per cent (N=121)

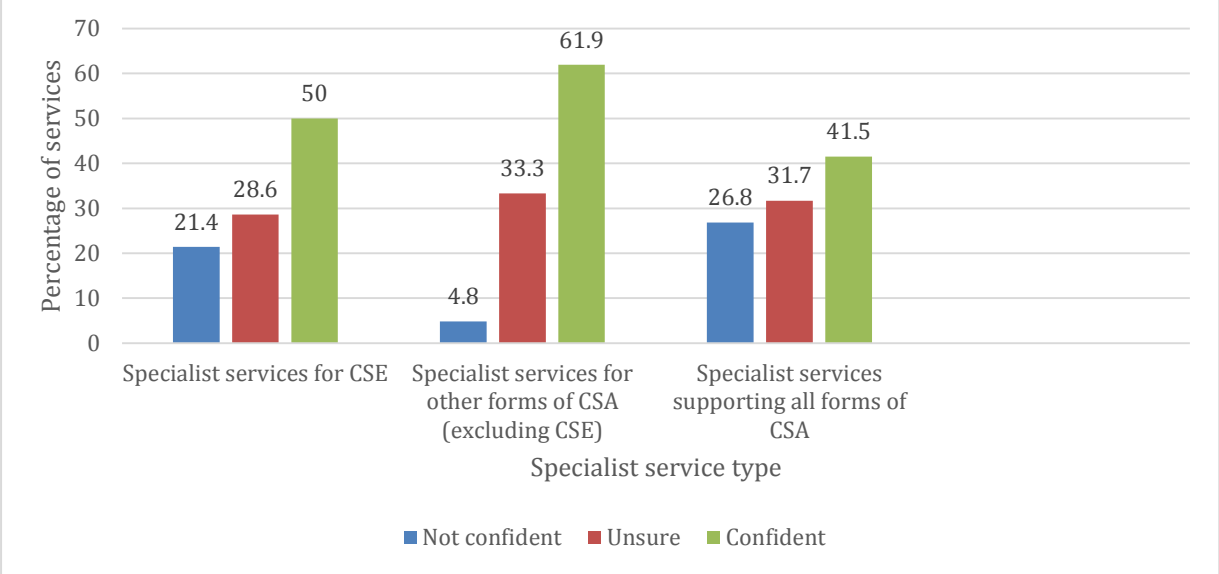


Across all sectors, the greatest proportion of services felt 'quite' or 'very' confident (combined into a single category 'confident') that they would receive further funding after the current funding period ends. The greatest proportion of services (81%) reporting confidence in future funding are statutory sector services (See Figure 3d above). Just under half (47%) of voluntary sector services felt confident that funding would be secure.

Only a slight difference was found between generalist (59%) and specialist (51.3%) services reporting confidence in further funding. Twenty-two per cent of generalist and 30% of specialist services said they were 'unsure' about the security of funding for their service, while 20% of generalist and 19% of specialist felt unconfident that their service would receive future funding. However, differences were identified within specialist service providers, as can be seen in Figure 3e.

Services for other forms of CSA (excluding CSE) had the most confidence that their funding would continue after the current round ends and those services which support all forms of CSA had the least confidence about future funding (See Table 3e).

Figure 3e: Levels of confidence in future funding among specialist services, by type of specialist service, per cent (N=121)



3.6 Changes to funding and commissioning and challenges for the future

Although many services reported being confident about continued funding, responses to open-ended questions in the questionnaire and interviews with providers and commissioners gave some insight into what form services in the future might take. A common theme in the responses revealed that even though services thought they would be funded in some way, this reflected a level of optimism rather than being an indicator that they had already secured their future funding. Concerns were expressed around the potential necessity to adapt services in terms of length of provision or scale.

Some services were optimistic because historically they had been funded or they were confident in the reputation of their service. A service provider from a large voluntary sector service in England said in an interview: *Our service only gets funded on a year on year basis, and we've currently just completed a service review so the commissioners can decide whether they're going to continue to fund the service. But they certainly have supported the service for the last 20 years. I think our commissioners certainly recognise the work that we do and the victims that we support and the good results and outcomes for the victim. But that's against the backdrop of their resources being cut, and obviously the funding, the money that's sometimes a struggle to raise.*

Another voluntary sector service provider (in an open-ended question) was similarly confident but recognised that the service may have to be altered in some way: *The organisation itself is quite good at getting funding, but it's a very competitive field. So it's always a worry. I mean the service will exist in some form or another, but whether we'll be able to extend it or carry it on with so many people involved in it will just depend.*

A statutory sector provider's confidence derived from the high priority currently given to CSA and CSE, as they reported in an open-ended question: *The other big impact is what children's social care do, and so if children's social care is, and in terms of child sexual abuse and child sexual exploitation; that is very high on their agenda and will continue to be so, and that may then be a driving force for development of other services. So there have been a few joint projects and stuff between us and them in recent years, and I suspect that will continue.*

Only one service noted in an open-ended question a positive change in the funding landscape, referring to the government commitment to fund rape crisis services: *Commitment from government to provide funding to ensure the sustainability of rape crisis*

centres [Voluntary CSA and CSE service, England]. However, the remainder of services expressed considerable anxiety and frustration in the open-ended questions within the questionnaire about funding.

Some providers described the increasing complexity and competitiveness of the commissioning process. An interview with a commissioner working within a Police and Crime Commissioner Office aptly describes what he calls a 'competitive and confusing commissioning environment':

> *Obviously [anonymised funding body] now comes under the local authority, they they're, they're so complex, so far I'm really, really struggling to understand it. What is commissioned through clinical commissioning groups as opposed to what is commissioned through [anonymised funding body], how the health and wellbeing boards work together to influence commissioning, how the children's partnerships… Now, we don't really have children's trusts anymore, and how they coordinate with health and wellbeing boards and how they're overseen by local safeguarding children boards, is I think even, well I don't think, I know because I've spoken to lots of people within all those groups and I think even they struggle to understand quite how they all relate to each other.*

Service providers, in the open-ended questions in the questionnaire, also mentioned instability and insecurity of current funding streams and referred to widespread reductions in funding sources, all which have had significant impacts on delivery of services to children and young people. Telephone interviews with commissioners support service providers' frustration with the lack of funding, as one commissioner in England put it: *Well, just less money to go round isn't it?* An NHS commissioner in Scotland said: *I think just now it's about the impact of the economic climate that we're in, where there are limited, finite resources*. Respondents reported, in open-ended questions in the questionnaire that the impacts of the economic landscape include closures to services, reduced availability of services locally due to these closures; reduced choice in services for children and young people; reduced capacity to deliver; increasing waiting times; increased thresholds and eligibility criteria; reductions and alterations in provision; and lack of funding for training and prevention.

In response to an open-ended question, 33 service providers reported cut backs and reduced funding opportunities as a key 'change' over the last 10 years, for example: *Reduced and more competitive funding opportunities available to charities* [Voluntary CSA service, Scotland]; *Cutbacks in funding for the voluntary services* [Voluntary CSA/CSE service, England]; *Less funding for spot purchasing services tailor made to meet YP needs* [Voluntary CSE service, England]; *and Reduced funding from social care* [Private CSA service, England].

Moreover, providers reported how these funding changes are impacting on the day-to-day service delivery to children and young people:

> *Loss of generic support services and severe budget restrictions have placed services like ours under threat. Our annual budget was cut by 50% and our service was threatened with closure within the last 2 years. I believe that many children are not getting the services they need because of financial cut backs. The danger is that victims' needs are minimised or redefined because of this* [Statutory service, England].

> *Lack of funding has reduced the services available and reduced services that are still available, also the uncertainty around funding can make it difficult to plan for the long term for services, hindering their development. Also impacts on the ability to offer long term counselling (when coming to the end of funding term) and the depth at which young people are able to engage with therapy* [Voluntary service, Scotland].

> *I am aware that within our voluntary organisation other sexual abuse projects have closed as a direct result of public spending cuts* [Voluntary service, England].

> *The negative effect of the recession and the local and national cuts which have led to a reduction in services offered in both statutory and voluntary sectors* [Voluntary service, Northern Ireland].

> *Lack of funding and funding cuts which reduce the amount of services available. There may be pressure to reduce the number of sessions offered to clients so that more clients could be seen. Our service has experienced major cuts and without new funding being sourced may not be able to continue. All of these would mean a reduction in service to some of the most vulnerable people in our society* [Voluntary service, Northern Ireland]

> *Lack of resources for children aged under 16. All former services for young people have closed. CAMHS has only recently received extra funding to cope with the demand but more choices of services are needed* [Voluntary sector, England].

Seven providers, in an open-ended question reported that funding has not kept up with increasing demand, for example: *Funding has not increased along with demand for the service. It is the same as it was 5 years ago when the main remit was awareness raising* [Voluntary CSE service, England]. Five providers felt that CSE services are being

funded at the expense of other types of CSA services: *It has been more in the public domain so it is an optimum time to develop new services however funding has not been provided to drive CSA forwards as it has with CSE. There is no joined up thinking, planning or practice delivery* [Voluntary CSA service, England].

Seventy providers[13] reported that funding would be an on-going challenge, particularly in the face of increasing demand, for example: *Sustained resources and funding to maintain the high level of intervention needed for this group* [Voluntary service, Wales].

Statutory sector services reported concerns about their ability to support children and young people responsively within the open-ended questions: *Continuing to provide a responsive, thoughtful service in a background of serious cuts and shortages across the sector* [Statutory service, England]; *The main issue within statutory services is that the need for general services and risk management squeezes provision for trauma work. Also the funding for previously targeted groups such as looked after children & learning difficulty children has ceased meaning it is much harder to provide the tailored packages that these young people need* [CAMHs, England]; and *Funding issues due to shrinking of statutory services* [Statutory council service, England].

One statutory provider bluntly challenged the government's priorities:

> *The scale of cuts to local authorities is eye watering and we may find that many valuable services and workers may be lost. It will take time to rebuild those service if the money ever becomes available again. It is strange that the govt. has highlighted CSA as a 'national threat ' but then the same govt's actions pose a national threat to the very services that children and young people need in order to cope and recover from CSA.*

3.7 Reflection and summary

The most striking finding in this chapter is the high anxiety expressed by service providers about the current funding landscape. At first glance, the 'confidence' reported by providers might mislead readers by suggesting services are secure. However, the messages contained within the qualitative data contrast starkly with this confidence. The qualitative data clearly illustrate that optimism about future funding does not equate to 'actual' future funding. While it is important that services which have built up their expertise for supporting victims of CSA/CSE feel

[13] The open-ended questions were voluntary and therefore we can only present the total number who mentioned funding

confident about their reputations, it is clear that even these services are operating in an unstable environment. It might be hoped that at least those services which are able to evidence good outcomes with victims would in reality be more secure financially, but the evidence suggests they are not. Rather, the respondents feel they are operating in an unstable environment, and that their futures rest on intangibles such as the tentative priority of CSA locally and nationally. Interviews with commissioners revealed an even more complex landscape where the process itself is highly complicated (so much so that even some commissioners do not understand it). This complexity and confusion about the commissioning process can present barriers to commissioning organisations in awarding contracts which can give services greater security and provide children and young people with un-disrupted and quality services they need to be supported.

Four-fifths of services in the current sample did not have 'indefinite' funding. This figure is similar to findings in the review of sexual violence provision in Wales that found that only 24% of services have secure funding, with the remaining services describing their funding as short term and insecure (Berry et al., 2015). Similarly, the vast majority of services in the present mapping exercise were operating to short term and insecure cycles of funding. Thus, despite government commitment and funding in the past five years, many service providers continue to operate in an environment that is "relentless and a constant challenge" (Rape Crisis England and Wales, n.d., cited in Henderson, 2012), with providers speaking of the considerable and constant pressure to chase new sources of funding and working all the time to renew and renegotiate existing funding, which challenges the day to day operation of services and delivery to children and young people.

Although few questionnaires were completed by CAMH providers, the few that did spoke in the open-ended questions of significant cut backs which reflect the experiences of CAMHs in other studies (Kennedy, 2010; Goddard et al., 2015). Both CAMH providers and providers who refer to CAMHs spoke of lengthy waiting lists in CAMHs, the loss of specialist work around trauma and raised thresholds for eligibility as a result of the funding crises they face. Sir Kennedy's review of the NHS – including CAMHs – concluded that services for children and young people are not good enough. Kennedy observed that: *Children and young people receive a disproportionately lower priority than adults in the imperatives of management and delivery, in the relative funding allocated, and in the realisation that investment in the care of children and young people will reduce the cost of care later in life* (Kennedy, 2010; p. 8).

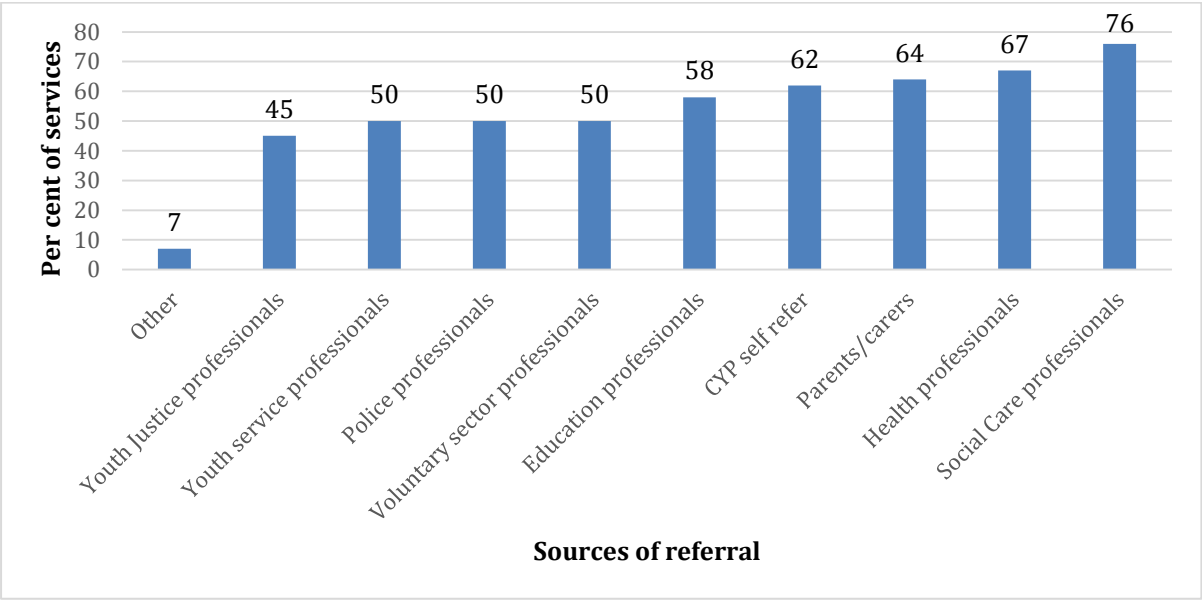
4 Current service use and pathways into services

This chapter moves on to focus on referral into services, including referral pathways, children and young people's eligibility for services and waiting times for services. It will also provide top-line referral data to provide a picture of current service use (during the financial year 2014 to 2015).

4.1 What are the referral pathways into services?

Figure 4a illustrates the range of referral sources into services. Social care professionals were reported as the most common source of referral across all the professional groups. Referral pathways into this particular sample of services are less developed for other professional organisations; referral rates were lower from voluntary sector services, police and youth sector professionals. Five respondents provided detail about other organisations who refer children and young people to them which included: Court, Housing Departments, via street work and via other gender-based violence specialist organisations.

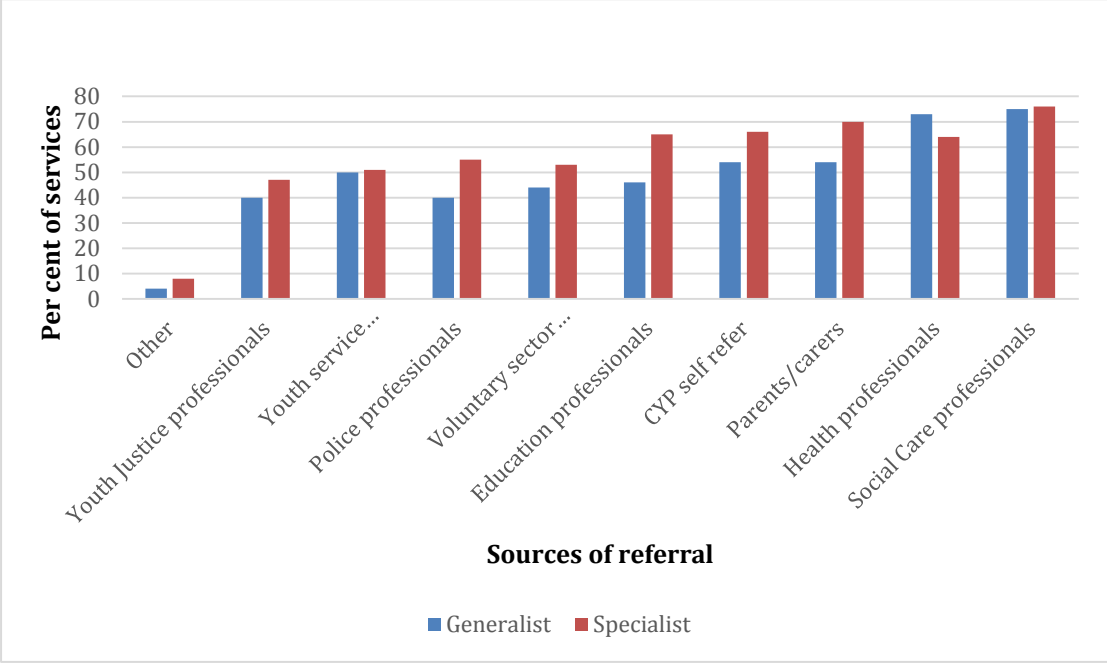
Figure 4a: Sources of referral into services (n=149)



There are some differences in referral pathways between generalist and specialist services (See Figure 4b). Both types of service share a similar pattern of referrals from Social Care, but generalist services reported more referrals coming from health

professionals than specialist services; however CAMHs make up one quarter of the generalist services, and so this may be skewing the data. Self-referral by children and young people and by parents and carers is more common among specialist than generalist services. The remainder of referral sources are slightly more common among specialist than generalist services in this sample.

Figure 4b: Sources of referral into services, by generalist or specialist service (N=149)



A limited amount of data from this audit suggests that referral into CAMHs remains problematic, as identified in the 2007 audit. The 2007 audit found that CAMHs had tight eligibility criteria and only accepted children and young people who have a clearly defined/diagnosed mental health need. A voluntary sector provider in England in the current mapping exercise echoed the 2007 findings during a telephone interview: *Our CAMHS service [in anonymised city] makes a clear line between therapeutic services for sexual abuse and therapeutic services where there is a clearly defined mental health need. So if there is no diagnosed mental health need for a child who has been sexually abused, they will not offer a service. For example, we might have young people who are significantly self-harming, who may have overdosed, but because the primary concern is sexual abuse they would be staying at our door and not getting a CAMHS service. So we do carry some quite high risk cases on that basis which is of concern to us.* [Telephone interview with a voluntary sector provider in England].

Some respondents suggested that CAMHs is getting even more difficult to access. *CAMHs criteria has changed to such an extent that fewer referrals meet their level of need* [Voluntary service, England]. Similarly: *Changes to CAMHs services and an apparent*

reduction in the numbers of children they are able to work with [Voluntary service, England]. A (non-CAMHs) statutory sector respondent provided a similar response: *Referrals onto specialist CAMHS not always meeting threshold or experiencing long waits still a problem due to decreased specialist CAMHS provision.* Finally, a voluntary generalist service respondent said: *CAMHs seem less accessible (in our local area anyways)*.

Only one respondent provided a positive view of referrals into and joint working with CAMHs: *We also work closely with CAMHs, so if there are any children and young people who would benefit from CAMHs intervention then we will refer on. CAMHs refer to us as well and sometimes we jointly work some cases where they counselling elements we can provide are important but they also need their mental health supported through CAMHs for a range of reasons* [Voluntary service, England].

A small number of participants cited 'improved referral pathways' as a positive change in the last 10 years: *Pathways becoming better established for abused and exploited young people* [Voluntary generalist service, England]. A statutory social care service in England concurred: *Increased liaison between agencies, which led to development of specific care pathways and support centres.*

4.2 Eligibility criteria

Most services have some form of eligibility criteria (See Table 4a). Age was reported as the most common criteria set, followed by geographical catchment area. Under half of the services (n=69) told us about other referral criteria[14].

Table 4a: Eligibility criteria for receipt of service[15]

	Number of services	Per cent of services
Age (n=142)	116	82%
Catchment area (n=145)	105	72%
Certain type of abuse (n=141)	61	43%
Gender (n=140)	15	9%

[14] This was an open-ended question. It is not possible to know whether more services would have told us about additional criteria if we asked them a yes or no question. Only those services that wanted to tell us more did, therefore this should not be generalised to the other services.

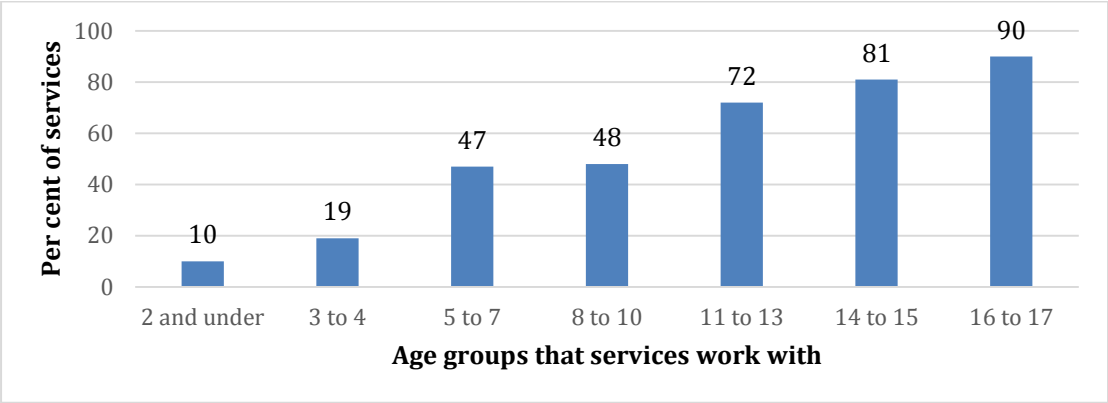
[15] The eligibility criteria were separate 'yes/no' questions and therefore the numbers of respondents who provided answers to the questions varied. The relevant total number of respondents who provided an answer is provided in the first column of the table.

Age

Age is the most common criteria for service eligibility: 85% of statutory services and the same percentage of voluntary services have an age criteria, while – bearing in mind the small number of private sector services in the sample - only 33% of private sector services do. Both multi-agency providers have an age criteria. Click here to see a full data table by sector.

It is quite striking in Figure 4c below that the percentage of providers offering a service increases with children's/young people's ages. Among this sample, provision for older children and adolescents is much more common than for younger children and provision for very young children is minimal. Twenty-five services reported that they also work with individuals over the age of 18.

Figure 4c: Per cent of services that work with different age groups of children (n=116)



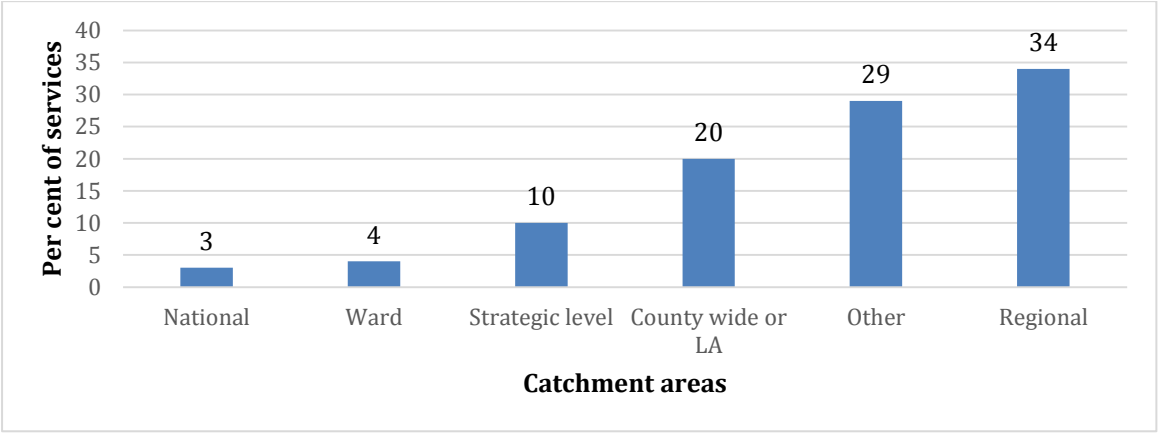
There are only slight differences in the percentages of generalist and specialist services by age group with the exception of under-two's, where a slightly greater proportion (15%) of generalist services provide for this group than specialists (8%). Click here for a comparison table by service type. Amongst specialist services, it is unsurprising that a greater proportion of specialist services that therapeutically support children who have experienced other forms of CSA (excluding CSE) provide for younger children than specialist CSE services. Click here to see a comparison table by specialist service type.

Catchment area

Just under three quarters (72%, n=105) of the services in this sample provide a therapeutic service to children and young people in a specific catchment area. Figure

4d shows that the largest proportion of services (just over a third) are regional services and very few services have national reach. Of those services which have an 'other' catchment area, examples include: areas covered by a police constabulary/ child abuse unit; city-specific and across a number of different local authorities.

Figure 4d: Eligibility criteria, catchment area (n=145)[16]



Type of abuse experienced

Of 141 services for which data were provided, 43% (n=61) require that potential clients have experienced specific types of abuse as part of their eligibility criteria. Nine generalist services (of 47 who answered this question) reported that type of abuse is an eligibility criteria for their service. Of the 97 specialist services in the sample, 55% (n=52) reported this. Of these, the most common form of abuse that secures eligibility is sexual abuse (n=52, 85%); this is followed by CSE (n=41, 67%); and 21% each of emotional and physical abuse. Sexually harmful behaviour is a criteria for 20% of services. A small number of services said there was some 'other' criteria, the majority of which is domestic violence, while one service requires a child or young person to have experienced neglect.

[16] Strategic level refers to the following in each of the four nations: In Scotland, Strategic Health Boards develop and provide health services based on the needs of the local community; Local Health Boards (LHBs) are organisations within the health service in Wales that have been set up to develop and provide health services based on the needs of the local community; In England, under the changes to the NHS that came into effect in April 2013, the 10 Strategic Health Authorities and the 152 Primary Care Trusts (PCTs), which looked after services at a local level, were replaced by NHS England and more than 200 Clinical Commissioning Groups; In Northern Ireland, the Health and Social Care Board (HSCB) is the organisation within the health service that is responsible for assessing the needs of their local population, commissioning services to meet those needs and monitoring the performance of services .

Among this specific sample, accessibility of the service by children and young people who have experienced child sexual abuse / child sexual exploitation appears to vary according to some funding providers[17]. For example:

- Among specialist services mainly funded by the voluntary sector, 78.6% of these services can be accessed by children and young people who have experienced (or are at risk of) sexual exploitation and 64.3% can also be accessed by children and young people who have experienced other forms of child sexual abuse;
- 86.7% of specialist services which reported no main source of funding are available to victims of CSE where only 80% can be accessed by victims of other forms CSA.
- Among specialist services with an 'other' source of funding, 62.6% are accessible for CSE victims and 81.3% are accessible for victims of other forms of CSA.
- All specialist services mainly funded by the NHS are accessible to victims of CSA (excluding CSE), while only 85.7% can be accessed by victims of CSE.
- 73% of specialist services funded by Social Care are accessible to victims of CSE and 81% are accessible to victims of other forms of CSA
- 100% of services funded by the DoJ are accessible to victims of CSA (excluding CSE) whereas only 62.5% are accessible to victims of CSE.
- 83.4% of services funded by the PCC are accessible to victims of CSA (excluding CSE) and the same percentage are accessible to victims of CSE.

Gender

Most services do not restrict eligibility based on gender; 125 of 140 services, or 89%, provide services for boys *and* girls. Three services (2.1%) are only for boys; of these, one supports boys over the age of 11 and the other support boys age 16 to 17. Twelve services (8.6%) are only for girls; of these, three support girls over the age of 11 and the remainder support girls over the age of 14. These findings are in line with a mapping study of CSE specialist services carried out by the National Work Group which found that 91% of the services they identified work with boys and girls (Warrington and Gulliford, 2010); and 77% of the services identified in the Welsh review of DV and SV services worked with males and females (Berry et al., 2014).

[17] It was not possible to test whether differences among type of specialist services are statistically significant because of the small numbers in some of the cells; thus these differences may simply be due to chance.

There was notable concern among some service providers in England and Scotland about the lack of – and loss of – services solely for girls (and women).

Other eligibility criteria

In response to an open-ended question, 69 respondents told us about 'other' eligibility criteria that must be met to receive their services. Each criterion indicates where two or more respondents cited this. Where only one respondent mentioned a criteria, these have been summarised in a paragraph following the list of bullet-points.

- A child must have displayed sexually harmful behaviour (n=7)
- A child must have experienced sexual abuse and witnessed domestic violence (n=5)
- Abuse must have been disclosed (n=4)
- A child/young person must have agreed to the referral (n=3)
- A child/young person must be in a safe and stable environment (n=3)
- Siblings of abused children/young people are also accepted (n=3)
- A child must have experienced any kind of trauma (n=3)
- A child or young person must have experienced any form of sexual violence (n=2)
- A child/ young person must have a safe carer involved (n=2)
- A child/young person must present a risk to others (for example, arson) (n=2)
- A child/ young person must be an open case to social services (n=2)
- Abuse must have been investigated (n=2)
- A child/young person must be homeless (n=2)
- A child/young person must be at very high risk of CSE (n=2)
- A child/young person whose emotional well-being has been negatively affected (n=2)
- Abuse must have been disclosed, investigated and there must be a safe carer involved (n=2)
- Eligibility criteria is defined by funders and may change (n=2)
- A child/young person must be allocated a social or youth worker (n=2).

Other criteria cited once by individual services include: where a child/ young person is living in a home with an adult who poses a risk to them, where a child/young person's emotional and physical needs need to be met, where a young person is a care leaver, where a child/ young person does not require an intermediary, where a child/ young person does not have an intellectual disability, where a child must be at risk of CSE as well as show concerns about sexually harmful behaviour, and where abuse must have been disclosed and investigated, where a child/ young person

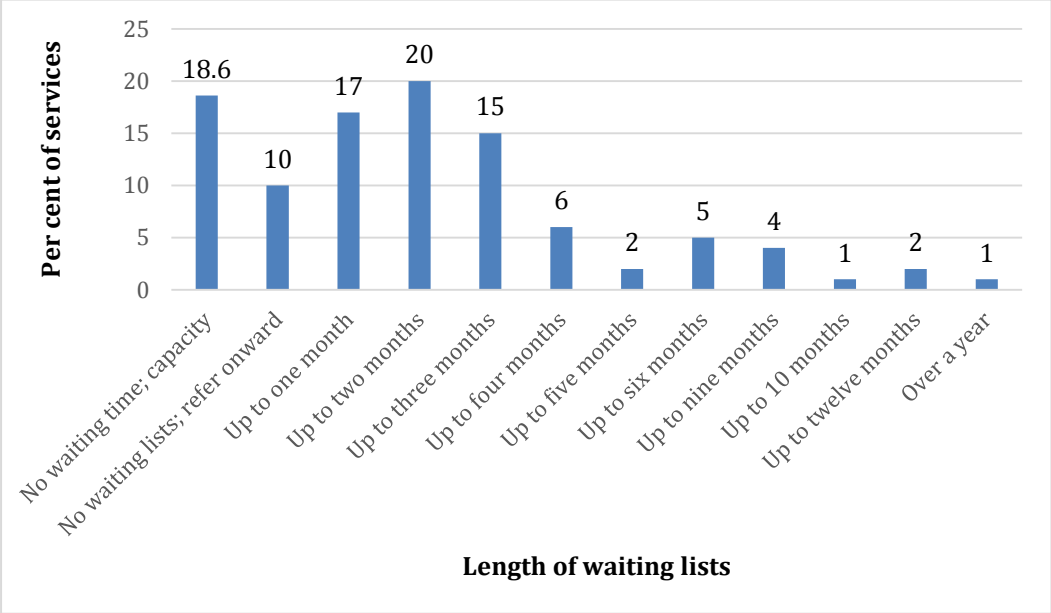
demonstrates a number of indicators of emerging personality disorder, where a child/ young person has failed to engage with CAMHs, where a child/young person has experienced any type of honour-based violence, where a child/young person must have experienced intra-familial abuse; where a child/ young person has a memory of and disclosed abuse, where a child/young person has experienced neglect, where no criminal investigations are underway, where a child/young person does not have contact with their abuser, where a child/young person is not subject to a Section 47 investigation, where a child/young person must be at risk of CSE only (not having experienced it), where a child/young person must be displaying a significant mental health issue and where social care is aware of the abuse.

Thus, children and young people are subject to a host of eligibility criteria in order to access a service in most cases, and these criteria highlight the complexity of understanding capacity within services.

4.3 Waiting times for service

Once a child or young person has been referred and accepted, some services are unable to provide a service immediately because they are already at capacity and have waiting lists. As Figure 4e illustrates, four-fifths of services do not have capacity to deliver their service to all accepted referrals, and operate waiting lists to manage this. Therefore only one-fifth of services have capacity and do not currently have waiting lists. Excluding those services which do not have a waiting time for any reason, on average, services have a three month waiting list. Only a small percentage of services – mostly in England - have waiting lists of over six months (8%). Click here for detailed data by nation. There were no apparent patterns by sector but a greater proportion of generalist services (26%) than specialist services (15%) reported that they have capacity and no waiting lists. Detailed data on generalist and specialist services can be found here.

Figure 4e: Waiting lists, per cent of services (n=129)[18]



Respondents were asked in the questionnaire if their service operates a maximum waiting time policy; in other words, is there a point at which they stop accepting referrals and placing them on a waiting list, because the waiting list becomes too long. Most services (n=79, 65.8%) do not operate a maximum waiting time policy. Of those who do (n=36), the maximum time for 23 (63.9%) is three months or less with the remainder having maximum waiting times of over three months and only one service reported a maximum waiting time of one year.

Qualitative responses to the open-ended questions provided some further detail about waiting lists. Several services mentioned the reduced provision in CAMHs: *Referrals onto specialist CAMHS not always meeting threshold or experiencing long waits still a problem due to decreased specialist CAMHS provision* [Statutory generic service, England]. A CAMHs respondent also expressed concern over waiting times within both statutory and voluntary sector services: *Increased waiting times for therapy services in both NHS and voluntary sector* [CAMH service, England]. A health commissioner also told us of waiting times that are unhelpful for children and young people: *I don't know if we as a statutory service or our partners have the capacity to meet the needs of each of the individual young people, children and young people because we have limited resources and the fact that we have waiting times isn't beneficial for children and young people because they need to support when they need it.*

[18] The categories in the table are not mutually exclusive; therefore some waiting lists may be shorter than stated. For example, the category 'up to 9 months' could mean that waiting lists are anywhere between 7 and 9 months.

One CSE voluntary sector provider reported in an interview that waiting lists are also being used to cope with imposed priorities from commissioners: *It's (the waiting list) probably around three to six months long. The reason it's got those broad parameters is that we do have an agreement with [anonymised) City Council who partly funds the service to prioritise certain young people. So young people who have been in care, subject to child protection plans are prioritised. So they will be seen at the earlier end of the waiting list. Then those young people who perhaps aren't presenting as a priority will have to wait longer.*

4.4 Current service use; referrals to services in 2014/2015

Confidently assessing the demand for services is a complex task, when even obtaining accurate figures about the numbers of children who are currently receiving a service is difficult. In order to understand current capacity, service managers were first asked to provide the numbers of children and young people who had experienced sexual abuse/ exploitation who were accepted after referral in the financial year 2014/ 2015. They were also asked, where possible, to provide a breakdown of referral by age, gender, ethnicity and disability. We felt this was important because the evidence suggests that certain groups of children and young people may be at higher risk of CSA/CSE. Furthermore, children and young people are not a homogeneous group and require different types of support and response and therefore knowing these demographic characteristics would be important for helping services to plan provision. Similar to the 2007 audit, this question proved to be a complex one and reliable statistics were difficult to obtain. Unfortunately, and in part because of this, the team were unable to calculate the shortage of therapeutic places which we hoped we could compare with the figure calculated in the 2007 report. In fact, the low data return on total referrals in addition to the overall lower response rate and low proportion of statutory service providers who filled out the survey meant that any such calculation would not be robust or comparable to the previous study.

In anticipation of problems with data return (which also was a problem in the 2007 audit), we included an open-ended question to obtain information from participants about why they could not provide the data we asked for. Box 4a provides examples of these reasons. The importance of this cannot be underestimated. It is not possible to get a full and accurate picture of capacity, need and demand when reliable referral data cannot be obtained.

Box 4a: Qualitative responses, reasons for not submitting referral data

Reasons for not submitting referral data in the survey	Quotations from services
23 participants told us that they did not have the time to obtain the figures for us	*"Sorry but it is simply a matter of time completing this questionnaire. I don't have them readily to hand. They are collected by the service"* [Voluntary service, Northern Ireland]
18 respondents reported that they do not record or collect this data	*Our stats system cannot count individual people only the number of contacts received. Also due to our volunteers commitment to client confidentiality I do not believe they record all cases ... both these things we are working on as a service.* [Voluntary service, England[
14 respondents reported that their method of storing data does not allow for easy access to some of the detail we were requesting	*"We capture the information, but it is stored in paper files and requires a manual review. Only some of the information is transferred to our small database for daily work management purposes"* [Statutory sector service, Scotland].
7 respondents told us that the nature of their generalist service meant that breaking down their data by CSA/CSE was not possible	*"As a generic service, we do not filter data in a way that allows us to analyse information about clients with CSA/CSE issues separately from other information, so I have had to leave some of the data blank" [Voluntary service, England]*
5 respondents told us that their method of collecting and storing the data did not allow for easy break down by the categories we had asked for	*Our age brackets are different 13 - 17 is the age bracket that we record. We do not at present collect ethnicity or disability information.* [Voluntary service, Wales]
2 respondents reported that they could not provide data because they do not disaggregate their statistics by age	*We don't break down our statistics, adult and child statistics are altogether* [Voluntary service, England]

Table 4b illustrates the numbers/ per cent of service providers who could provide data on total referrals, and referrals by demographic characteristics. Of 132 services (out of 149) where a respondent answered our request for total referrals, only 91

(67.9%) said that they could provide this data[19]. A greater proportion of specialist services (69%) said they could provide referral data than generalist services (46%) although four generalist services could provide total referrals of all children and could estimate the percentage of children and young people they work with around CSA/CSE. Where they were able to do this, we calculated the percentage from their total referral figures and used that as the total number of referrals for CSA/CSE. Click here to see how many services could provide this data by country.

Only those respondents who could provide total referral data were asked follow up questions regarding the breakdown of referrals by gender, age, ethnicity and disability, which is why the numbers in column one of Table 4b drop significantly.

Table 4b: Total number and per cent of services for which referral data is available, by total and demographic characteristics

Referral category	Number and per cent of services
Total referrals (n=134)	91 (67.9%)
Gender of referrals (n=78)	64 (82.1%)
Age of referrals (n=87)	51 (58.6%)
Disability of referrals (n=89)	49 (55.1%)
Ethnicity of referrals (n=89)	49 (55.1%)

Total number of children and young people accepted after referral

The total number of children and young people accepted after referral in 84[20] services across the UK was 5733[21]. The vast majority of these (4462 children and young people) received support from 65 services in England (Click here for a detailed data table by country). The data for Northern Ireland, Scotland and Wales is not robust enough to calculate any averages, but for England, the data shows that, on average, there were 68.25 referrals to a service (services accepted a range of between 2 and 252 children and young people). However, the median of the current sample is 49, indicating that there are some much larger services in this sample pulling the average upwards. When assessing *only* the specialist services, the average is slightly higher than the combined average at 74.76 referrals per service, with a median of 54.

[19] Accounting for the entire sample of 149, this represents only 60% of the sample that could provide overall referral data.

[20] While 91 services provided referral data, three were removed (see footnote 28) and an additional four either did not provide data or provided data in a format that could not be analysed; thus data from only 84 services could be analysed.

[21] It is unknown whether this figure includes children and young people on waiting lists.

Table 4c: Total number of referrals, minimum/maximum number of referrals and average/ median number of referrals, by all services (generalist and specialist combined) and by specialist services only

Total number of referrals		Minimum/ maximum number of referrals		Average and median number of referrals	
All services (n=88)	Specialist services only	All services	Specialist services only	All services	Specialist services only
5733	4710	2/ 368	2/ 368	68.25 (49)	74.76 (54)

Demographic characteristics of children and young people referred

Far fewer services were able to provide referral data broken down by demographic characteristics than by the total number of referrals overall. Again, caution is urged in interpretation because of the wide variability in referral across all demographic characteristics. There were on average more girls accepted after referral (on average of 53 girls per service, but there was a median number of 37 girls) than boys (on average 21 boys per service, but there was a median of 12 boys). Click here for full data table on gender.

By age, the largest group accepted to a service after referral were children aged 10 to 15 (49% of all referrals). The 16 to 17 year-old age group represents just over a third of all referrals; and the 9 and under age group constituted the smallest percentage of all referrals at under 20%. This holds across generalist and specialist services. CSE only services reported no referrals of children under the age of 9, and by far the highest average number of referrals for the age group 10 to 15. Click here for a full data table on age.

Referrals by ethnicity were also widely variable. The largest average was, unsurprisingly, White British (on average there were 54.44 referrals based on 36 services) followed by 'other' ethnicity (on average there were 25.67 referrals per service, based on 15 services). The next highest average number of referrals was for the Black/Black British category (10.96 referrals on average) and all other categories reported much lower averages. Click here for a full data table on ethnicity.

4.5 Reflection and summary

The data in this chapter highlight a number of points of interest for reflection. Firstly, while referral pathways are well developed with social care, they are less so with other professional groups such as the police and other voluntary sector services.

While limited, the findings reported above regarding referrals to CAMHs are reflected elsewhere in the literature. The review of London SARCs similarly found issues with SARC professionals struggling to access CAMHS, identifying strict access criteria and long wait times for assessment and treatment. The authors suggested that it was financial cuts to CAMHs in recent years that are in part responsible for this reduced accessibility (Goddard et al., 2015). However the responses above also suggest it is CAMHs eligibility criteria which frames provision according to a mental health diagnosis which also reduces accessibility for children and young people.

However, it is not only CAMHs imposing eligibility criteria on service access. Eligibility criteria are common across all of the services. Numerous providers talked about eligibility being shaped by commissioners and waiting lists being used to manage 'priority children' in response to this. For some services, some groups of children and young people may be waiting indefinitely or for a long period in order to receive a service.

Age is one of the criteria that stands out more starkly among the others. Among this sample, far fewer services are provided to very young children than to older children and in particular adolescents. It may be that that the patterns and dynamics of disclosure of abuse may be influencing the availability of services for younger children. The research tells us, for example, that it takes a very long time for many children to tell an adult what has happened to them (or, they may try to tell in different ways but not be heard by adults) (Cossar et al., 2013). Research has found that it can take on average 8 years for a disclosure to be made, heard and/or acted upon which means that knowledge of CSA may not be known until children are somewhat older (Allnock and Miller, 2013). Additionally, we know that the impact of CSA may not appear immediately but emerge as children grow older – what Beitchman et al. (1992) call 'sleeper effects'. Thus it may be that funders and commissioners do not see a need for services for younger children. Also the inclusion of CSE specialist services – most of whom work with children over age 10 – are influencing the sample on this issue.

Qualitative responses by providers show concern that the current focus on CSE (and older children) comes at the unfortunate expense of services for younger children who have experienced CSA. Alternately, the skills and expertise required for working with younger children may be in lower supply than that needed for working with older children. Whatever the case, the data, alongside qualitative responses of providers, indicate that services for younger children who have experienced CSA are less common than those for older children.

Both the current mapping exercise and 2007 audit highlighted the challenges in obtaining data from services on the number and characteristics of clients being supported. Current service use was difficult to assess given the low return on data from many of the services. It was similarly difficult to obtain plentiful data from services in the 2007 audit. The current sample, however, on average appear to contain some much larger services than the 2007 sample, as observed in the average (and median) number of referrals accepted in 2014/2015. However, it is important to remember that there is considerable variability across the services. The data for specific demographics of children and young people accepted to the service were even more difficult to obtain, and great variability exists within these figures also. However, the pattern of service use is quite similar to the 2007 sample, with more girls and more White British children and young people using services than boys or children from BME communities.

5 What kind of provision do children receive following acceptance into the service?

This part of the report describes the types of therapeutic support children and young people receive once they are accepted into and are actually receiving a service. This includes the models of or approaches to therapeutic work, the ways in which services work with children and young people who have additional needs and the accessibility of services.

5.1 What models / approaches do children and young people receive once accepted to a service?

Service providers were asked to identify which therapeutic model(s) of provision/ engagement/ therapy they deliver to children and young people. The data presented here provides a very broad-brush picture of models of and approaches to provision. In reality, different models of provision are comprised of different strands of practice and can be undertaken within a range of contexts, such as individual or group settings. However, it was not the intention of this mapping exercise to evaluate specific models or interventions, and thus data on how services are specifically applying these therapeutic models is limited. Table 5a presents the most common models/ approaches of delivery reported. Respondents could choose more than one option, and therefore the figures in the table do not add up to 100%.

Table 5a: Therapeutic models of provision/ engagement/ therapy on offer within services (n=149)

Sector	Number of services/ per cent of services
Therapeutic relationship	100 (67%)
Creative (art, play, filial, drama)	100 (67%)
Counselling	87 (58%)
Attachment work	71 (48%)
Cognitive behavioural approaches	65 (44%)
Narrative/story work	65 (44%)
Sexually harmful behaviour	59 (40%)
Socio-educational work	56 (38%)
Family work	53 (36%)
Group	50 (34%)
Psychodynamic	45 (30%)
Other	29 (20%)
Transactional analysis	22 (15%)
Sensory motor	16 (11%)

In an open-ended question, 28 respondents named 'other' forms of support provided within their services. These can be viewed in the annex by clicking here. The 'therapeutic relationship' and creative therapies were the most common ways of engaging with children and young people across services. Counselling was also common in over 50% of services. Within these services, there are some patterns evident between generalist and specialist services and between statutory and voluntary sector services – although these were not tested for statistical significance given the low numbers of services within some categories:

- The 'therapeutic relationship' is more commonly applied within specialist services (72%) than generalist services (58%); this was mentioned by a relatively equal percentage of statutory (75%) and voluntary (66%) sector services.
- Creative therapies are also more commonly delivered within specialist services (75%) than generalist services (50%); these are slightly more common among voluntary sector services (70%) than statutory services (60%).
- Counselling is delivered fairly equally by specialist services (58%) and generalist services (54%); it is delivered in relatively equal measure in statutory and voluntary sector services.
- Cognitive behavioural therapy is also delivered fairly equally by specialist services (45%) and generalist (44%) services; and it is more common among statutory sector services (60%) than voluntary sector services (39%).

Principles of working with children and young people

In addition to reporting on specific models or ways of engaging with and supporting children and young people, respondents – in an open-ended question - mentioned other general principles applied within their services. Ten respondents mentioned that they worked in a 'client-centred' way: *Therapeutic work is client centred and empathic, using a range of tools, including seemingly 'regular' activities, such as walking, drawing, music making/listening, creative activities as well as talking sessions and more clinical interventions.* [Voluntary sector CSE service, England]; 10 respondents also mentioned working with a 'safe-carer' as part of the therapeutic work: *Parents and carers of children who have been sexually abused can play a really important role in helping their child recover. They are offered some individual support and some joint sessions with the child* [Voluntary sector CSA service, England]; 7 respondents described the importance of offering a safe and confidential space: *Our service provides counselling and allied support to 5-18 year olds. Our therapeutic intervention provides a safe, confidential space for the young person to share their thoughts and feelings* [Generalist voluntary sector service, England]; and 10 respondents said they ensure that their

work is carried out by qualified and/or trained therapists/workers: *The service is delivered through a team of qualified counsellors who have undergone a six day training course in this specialist area* [Specialist voluntary sector service, England].

Three respondents cited empowerment and feminist principle as underpinning their work. Feminist principles are at the core of the rape crisis service model and these three service providers expressed concern at what they see as the loss of a gendered approach to sexual violence: *Evidence shows clear gender differences - young people are under pressure and are learning the wrong script about gender roles, expectations and behaviours. In order to effectively support young people, avoid victim blaming and prevent violence and abuse it is important to understand and take account of gender inequality and gender differences. The main challenges for women's support services is the lack of acceptance of the gendered nature of CSE. Within the violence against women and girls sector it is widely accepted that CSE happens to young people of all genders however women and girls are disproportionately affected. There is a notable resistance within external services of the gender based analysis of the link between CSE and gender particularly when working with young girls* [Voluntary sector rape crisis service, England].

Are there differences between therapeutic support provided for CSE and other forms of CSA?

Although it was not possible to test for statistical significance, a pattern is evident among specialist services regarding age of children and young people supported by services. The specialist CSE services in this sample typically support older children while specialist services for other forms of CSA typically support younger children. Cognitive-behavioural therapy (CBT) is more commonly provided among CSA services (50%) than CSE services (26%). Family therapy is more common among the CSE services (47%) than CSA services (27%); as is group therapy, where 53% of CSE services offer this compared with only 14% of CSA services. There were only slight differences between these services on all other models/methods of supporting children and young people.

Respondents working within both specialist CSA and CSE services mentioned relationships as central to working with children and young people. For example, CSA providers talked about this relationship being crucial for children to begin processing their experiences, sometimes referring to this relationship as the 'therapeutic alliance':

Therapeutic support is establishing a relationship of trust between practitioner and client, in which the client is facilitated in starting to think about or process difficult, traumatic or significant events in order to be in a position to think more positively about the future. [Voluntary sector specialist CSE service, England]

CSE providers reported more broadly about a 'therapeutic relationship' to begin working with young people around difficult issues. This particular provider's response highlights that this relationship can be understood as therapeutic even if not delivered by a qualified therapist:

Whilst we are not 'therapists' the work we do centres around building a trusting relationship that enables the child or young person to feel safe enough to explore difficult issues such as self-esteem, confidence, drug and alcohol use, sex and relationships, eating disorders and self-harm [Voluntary sector CSE service, England].

The quote above also highlights the importance of a holistic approach, and reflects work within CSE services to address harm reduction and immediate needs.

Sexual assault referral centres (SARCs)

The current mapping exercise found that at least some SARCs report that they do not provide short-term counselling or therapeutic support. SARCs that screened out of the audit did so because they did not self-define as a service that provides emotional support to children and young people following CSA/CSE. This reflects findings from the London review of the Havens (Goddard et al., 2015) which found a lack of psychosocial support being offered as well as problems encountered by SARCs in accessing other local agencies including CAMHs. The review found that the London SARCs were not knowledgeable or linked in well with local third sector services. It is not possible to know this level of detail within the current data. However, there was one example of a SARC providing psychosocial support and provided us with a detailed overview of their provision, which includes short-term counselling:

Our service primarily provides forensic medical examinations to victims of rape and sexual assault, regardless of age or gender. When a client attends our service for a medical examination (via the police or self-referral) the client is supported through the process by a specially trained female Crisis Worker. The Crisis Worker is to be an advocate for the client and ensure their needs are met and they are supported to make decisions and have all options available to them, explained to them. Clients are able to access our service and have a therapeutic medical examination whereby the examiner may be checking for injury and will discuss medical needs such as prophylactic medical or screening for sexually transmitted infections. All clients are offered counselling following their attendance or contact with our service. Clients who give their consent can be referred for

counselling internally or externally. Internally they can access a male or female counsellor and access up to 12 counselling sessions.

5.2 How long is the typical specialist service delivered to children and young people?

Respondents from specialist services were asked to report how long children and young people typically receive a service once accepted. The majority of specialist services reported providing a longer-term service (more than 12 weeks) or else for as long as the child or young person needs. Combined, this means that 78 out of 91 services that provided data (or 86%) provide longer services for children and young people who require it.

Table 5b: Typical length of time that services are provided for (n=91)

Length of service	Longer-term (longer than 12 weeks)	Short to Medium term (less than 12 weeks)	Depends on the need of the child (will provide a service for as long as it is required)	Total number of services
Number of services (%)	46 (50.5%)	7 (7.7%)	38 (41.8%)	91 (100%)

5.3 When are services accessible to children and young people?

Services most commonly delivered their provision during the weekdays, typically following a pattern of '9 to 5' office hours. This type of support was five times more frequent than evening support; nearly 16 times more likely than support provided over the weekend during the hours of 9 to 5; and 46 times more likely than support provided in the evenings over the weekend. Only a small number of services offer 'out of hours' provision (n=36) and even fewer offer emergency provision (n=20).

5.4 How do service providers respond to children and young people with particular / additional needs?

We asked service providers to tell us how they would provide for children and young people with particular needs. Respondents were offered a list of issues some

children and young people may be living with or particular needs some children and young people may have and were asked to tell us whether they:

a) Tailor their service to the child/young person's needs;
b) Provide an additional service to the child/young person;
c) Refer a child to a different service;
d) Deliver the service as usual because it cannot change; or
e) Deliver the service as usual because it would be adequate to meet the need.

There was a significant amount of data which cannot all be presented here. Box 5a highlights the most common strategies for meeting the needs of these children (all adding up to over 90% of services). The boxes highlighted in blue draw attention to those issues services are less able to work with in-house.

Box 5a: Most common methods of responding to children with particular needs

Particular needs	Most common methods of meeting the needs
Learning disabilities (n=128)	Tailor provision (68%) Deliver as usual, would meet need (25%)
Physical disabilities (n=127)	Tailor provision (55%) Deliver as usual, would meet need (37%)
Substance use (n=128)	Tailor provision (26%) Deliver as usual, would meet need (36%) Refer on to another service (30%)
Eating disorders (n=126)	Tailor provision (29%) Deliver as usual, would meet need (46%) Refer on to another service (20%)
Self-harm (n=127)	Tailor provision (30%) Deliver as usual, would meet need (61%)
BME communities (n=125)	Tailor provision (27%) Deliver as usual, would meet need (72%)
Other minority ethnic communities (n=125)	Tailor provision (32%) Deliver as usual, would meet need (66%)
Girls and young women (n=125)	Tailor provision (24%) Deliver as usual, would meet need (75%)
Boys and young men (n=125)	Tailor provision (20%) Deliver as usual, would meet need (72%)
Looked after or accommodated (n=125)	Tailor provision (24%) Deliver as usual, would meet need (71%)
Young offenders (n=116)	Tailor provision (22%) Deliver as usual, would meet need (38%) Refer on to another service (36%)
Lesbian, gay, transgender or bisexual (n=116)	Tailor provision (21%) Deliver as usual, would meet need (77%)
Additional mental health needs (n=124)	Tailor provision (30%) Deliver as usual, would meet need (54%) Refer on to another service (12%)
Ritual abuse (n=124)	Tailor provision (36%)

	Deliver as usual, would meet need (52%)

Most service providers reported that they could meet most children and young people's needs in-house. A fifth to a third of services – across all the needs listed – would have to tailor their provision in some way but they would be able to support these needs within the service. For those children/ young people with particular needs around substance use, eating disorders, young offending and additional mental health needs, some service providers reported they would have to refer the child or young person on to an additional service. Presumably this is because those services do not have the skill in-house, or the child / young person needs the support of a wider range of specialist services to meet their needs.

5.5 What do service providers see as the most significant changes to provision that have occurred since the previous audit?

The questionnaire included an open-ended question asking respondents to identify the top changes in the field that have occurred in the last ten years. The respondents gave highly varied answers but the most common theme centred around the increased awareness, recognition and priority given to CSA and CSE as well as emerging issues for the field.

Increased awareness, recognition and priority of CSA and CSE

By far, the top change in the field identified by respondents was the increased profile of CSA and CSE that was noted by 65 service providers. The responses varied, however, in terms of the target of that awareness. Nineteen respondents mentioned 'general' awareness without much specificity, for example: *Greater understanding of the problem [*Voluntary sector service, England].

Twenty-two respondents cited that there was greater awareness among professionals: *A greater awareness across all professionals of CSA and CSE* [Voluntary sector service, England]. Among these, 7 respondents said that there has been a positive shift in policing this issue, for example: *At last the police are responding to CSE, albeit there is still a long way to go* [Voluntary specialist CSE service, England] and *More co-ordinated response from Police* [Voluntary specialist CSA service, England].

Awareness within national and local government was cited by 16 respondents: *National recognition and need for statutory service change* [Statutory service, Scotland]. Fourteen respondents also mentioned the considerable media attention that has

surrounded CSA/CSE: *Due to the number of high profile cases and high volume incidents, with respective media coverage, there has been significant increases in reporting* [Voluntary generalist service, England]. Five respondents referred to increased awareness among young people, which has led to the increased reporting observed: *Awareness has increased due to media etc, as a result more young people are able to come forward* [Voluntary sector generalist service, England]. Other related responses include improved knowledge about CSA/CSE emerging from research (mentioned by five respondents); improved identification of CSE associated with the increased awareness (also mentioned by five respondents); and there was a belief among thirteen respondents that increased awareness is leading to increased demand, and as a result, services are struggling to cope.

Emerging needs and issues

Seven respondents cited the emergence of internet/online abuse as a key concern that has emerged over the last 10 years: *The biggest change – and challenge is internet abuse/exploitation/grooming* [Voluntary CSA service, England]. 'Porn culture' was also cited as a concerning new trend among five respondents. Thirteen respondents described how they felt that child sexual exploitation was an emerging issue, and simultaneously, they raised concern about the emphasis on CSE at the expense of CSA: *The subsuming of CSA into CSE - although it is part of the same issues around sexual violence the interventions are different and this is not recognised* [Voluntary CSA service, England]. A voluntary sector CSA/CSE service in Scotland also noted this: *There has been a big focus on exploitation which has in a way detracted from the overall issue of child sexual abuse and the lack of recognition that this is exploitation*. Private sector services also share this concern: *Need to ensure that emphasis on child sexual exploitation and historical abuse does not reduce focus on intra-familial child sexual abuse* [England].

A small number of services also cited increasing referrals of girls for sexually harmful behaviours; a growing lack of respect for girls, particularly white working class girls; and the increased recognition of mental health needs of children and young people.

5.6 Reflection and summary

Since the 2007 audit, little has changed regarding the evidence and knowledge base of therapies/ approaches used with children and young people who have experienced sexual abuse and exploitation. Some small scale evaluations have been

carried out, but robust and long-term studies remain absent. The NSPCC are currently coming to the end of a longitudinal evaluation of their new therapeutic service for CSA which will helpfully add to the evidence base; and the International Centre are likewise in the middle of a realist evaluation of the Hub and Spoke model of service delivery for CSE. However, more research and evaluation with regard to 'what works' is required to establish a better evidence base in this area.

In particular, the 'therapeutic relationship' was not specifically considered in the 2007 audit, but is very common amongst the services in this sample. The concept of the 'therapeutic alliance' has traditionally been considered the relationship between a therapist and a client; it is the means by which a therapist and client hope to engage with each other to effect beneficial change for the client. In the context of CSE specialist services, the therapeutic relationship means something somewhat different. While the therapeutic relationship or 'alliance' in wider CSA services has typically meant the relationship between the child and the therapist, in the context of CSE support, warm and trusting relationships are at the heart of creating safe and stable environments for young people – this can be not only with therapeutic providers and support workers but with other people in their lives such as a foster carer (See Shuker, 2013 for example).

Accessibility to services in the current sample is limited largely to 'office hours' of 9 to 5. Weekend and evening provision is scarce, and even more scarce are out of hours and emergency services. For younger children, this may present problems because accessing the services is usually provided via their parents/carers who may be unable to access the service during office hours. For young people, these times may clash and interfere with their schooling and/or working hours. Moreover, need for emotional support and/or crises do not always occur during typical office hours and thus some children and young people will be without support during the times they need it the most. The relative inaccessibility of services is likely related to the problem of funding/resourcing and other issues which reduce accessibility of the service.

Finally, service providers' report that they are able to provide generally for a wide range of issues that children and young people may be living with and particular needs that they may have. Four complex areas – eating disorders, substance abuse, young offenders and children with complex and additional health needs – are the needs/issues most likely to mean that services need to refer these children onto a more specialised service.

6 Met and unmet need

This report has already highlighted some gaps in provision in previous sections, and this final section of the report presents additional data on the gap between provision and need. In the 2007 report, the authors used Census data, prevalence data and referral data from the survey to calculate the shortfall in therapeutic places across the United Kingdom. It was anticipated that the previous calculation could be undertaken again using new Census, prevalence and referral data in order to compare with the previous figures. However, as described in Chapter 4, the referral data we received from service providers in the current mapping exercise are limited with only 60% of the entire sample of 149 services providing usable data on total referrals accepted into their service during the financial year April 2014 to March 2015. In light of this limitation and others described earlier in the report, it was decided that data from the current study should not be used in the same way to calculate the gap between need and provision as it was in 2007.

A range of data from the current survey, however, does allow for an exploration of the gap between need and provision amongst the *current sample* only. The first section of this chapter presents data on service use and capacity during the financial year 2014/2015; the second section of the chapter presents data on projected service use and capacity during the financial year 2015/2016. In a final summary section, the data from these two sections is combined to give a picture of changing capacity in light of increased demand.

6.1 Variations in 'capacity'

Several questions were included in the questionnaire which aimed to understand what service providers mean by 'capacity'. We found three different groups of services among the sample:

1) Those who have capacity to support all children and young people immediately
2) Those who do not have immediate capacity to support all children and young people, but who have waiting lists
3) Those who have no capacity to see children immediately, and their waiting lists have become too long to sustain and so they are turning eligible children and young people away.

Immediate capacity to support children and young people

First, we asked services to tell us if they typically operated waiting lists (presented in chapter four of the report). Among those who responded, we found there were a group who expressly said they did not have a waiting list because they could provide support to children and young people who need a service, at the time they need it. This was the case for just under one-fifth – or 19% - of services.

No immediate capacity but operating active waiting lists

A majority of service providers (n=92) typically do not have immediate capacity to provide a service to a new child or young person, but do operate waiting lists for the service. We asked those with waiting lists whether they had to stop accepting referrals in the last year to avoid an overly long waiting list. Most (n=71 or 82% of services responding to the question) did not have to stop accepting referrals last year. Of these, 69% had waiting lists of up to 3 months, and 30% had waiting lists of between three and twelve months.

Turning away eligible children

Fourteen (or 18.4%) of those services who were operating waiting lists at the time of data collection were over-capacity and had to stop accepting referrals to avoid overly long waiting lists. Thirteen service providers told us something about what happens to those children and young people whose referral they could not accept. Six of these refer the child / young person back to the referring agency, requesting re-referral at a later date. Two services signpost clients to other services. One service said they consult with professionals on the case while waiting for a re-referral at a later date. One service refers children/young people on to another local service. Finally, three services noted that they 'fast track' where possible to reduce delay. This means that the services will prioritise children and young people who may be assessed at higher need to ensure they get a service sooner, but ultimately this will mean de-prioritising other children deemed to have less serious need for the service.

A small number of services also told us that capacity was 'not the issue' but that certain commissioning/funding arrangements prevented them from seeing all eligible children:

- Funding is on a spot-purchase basis – many referrals are not approved for funding, and therefore there is a gap in the service

- Two services said they have capacity but lack the funding to provide the service[22].

How many children and young people were services unable to provide a service to in the financial year 2014/2015 – and for what reason?

Using referral statistics provided by services, we were able to calculate the actual numbers of children and young people (among only those services who provided data) who did not receive a service last year, and the reasons why. While this cannot be generalised to the remainder of the services in the sample or beyond, it provides an insight into patterns and dynamics of referrals and indicates the way that services are operating when they are encountering problems with capacity. Table 6a presents this data for all services who responded to this question (n=129).

Table 6a: Number of children and young people who did not receive help in the financial year 2014/2015, by reason[23] (n=717)

Reason	Number of children/ number of services
Service lacked expertise to support client	216 (8 services)
Service lacked capacity to provide a service to the client	241 (15 services)
Service was unable to provide a service to the client for another reason	260 (11 services)
Total number of eligible children and young people who did not receive a service	**717**

Click here to see this data broken down by country; here by sector; and here by service type.

[22] It is not entirely clear what the respondents meant by this. It could mean that they have enough staff to see additional children and young people, but that they do not have funding to support the actual work with them.

[23] Although only 16 service told us that they had to stop accepting referrals in the past year, it was clear there were more services who were unable to provide a service to children and young people for reasons of either capacity or lack of expertise within the service. It is not clear why they indicated that they had capacity, but then told us about children they could not support.

6.2 Service estimations of met and unmet need over the next 12 months

The previous section presented data from the financial year 2014 and 2015. We also, however, asked service providers for future projections of service use and capacity in the coming year. Most services (74.5%, 96 out of 129 services) do not anticipate that they will have to stop accepting referrals in the next 12 months. Click here to see a data table comparing this information by country and here for a comparison by sector.

The remainder of this section presents data on met and unmet need in the coming 12 months, using referral projections, among the services that provided this data. This was calculated using a) the number of children and young people that services anticipate they will be able to support; b) number of children and young people that services anticipate they will not be able to support; and c) calculating the percentage difference in these figures to provide an estimated gap in provision among these services. Only services who were able to provide *total referral data for the 2014/2015* financial year were included in the analysis to ensure comparisons could be made between 2014/2015 and the year following.

a) Anticipated number of children and young people services *will be able to support*

Service providers in 86 services provided estimates of how many cases they project they will be able to provide a service to over the next 12 months. They estimated they would be able to support a total of 5,596 children and young people (which is nearly equivalent to the number of children and young people they were able to support in the financial year 2014/2015 = 5,733; see Chapter 5 for a breakdown of current service use. Services anticipate next year to be able to provide 1183 of these places in generalist services, and 4413 places in specialised services (a total of 5569 places). Click here for a data table by country; and here by sector.

b) Anticipated number of eligible children and young people services will *not* be able to provide support to in the next year

Fifty-one services provided this data and estimated the likely unmet need to be 1130 children and young people. In terms of type of service, the anticipated unmet need amongst the generalist services is 362 places, and amongst the specialised services in 768 places. Click here for a data table by country; and here by sector.

c) Estimated gap in provision in the coming year

As presented above, services provided estimates of what met and unmet need there would be in the next 12 months within their own services. Taken together these services estimate an anticipated need for **6726** places amongst their potential client groups, with the majority of places in the voluntary sector (See Table 6b). The services which responded to this survey anticipate being able to meet 83% of the need that they expect to be referred to their services over the next 12 months. These services predict that they will **not** be able to help around 2 out of every 10 children and young people who may require support. It is not possible from the data to estimate how many of these young people will be able to receive support from services not included in the mapping exercise.

Table 6b: Anticipated levels of need in 2015-16 within the services that responded to the survey

Anticipated level of need in 2015-16	**Total**
Number of clients that services expect to be able to support	5596
Number of clients that services expect not to able to support	1130
Total number of clients that anticipated to require support from these services	**6726**

In summary:

1) Services that responded to the survey reported that over the last 12 months they have supported 5,733 children and young people after referral (See Chapter 4 for these calculations).
2) They anticipate being able to provide a similar amount of support to children and young people in the next 12 months (5,596 children and young people). They are, however, anticipating a higher level of need next year than they are able to support.
3) In the year from April 2014 to March 2015, the level of unmet need was 717 children and young people. Adding this to the number of children and young people which services were able to meet allows for the calculation of the gap: 5733[24] + 717[25] = 6450; which was an approximate gap in provision of 12%.

[24] Total number of children referred and accepted for a service in 2014/2015 (see Chapter 4)

[25] See Table 6a

4) In the coming year, the level of unmet need will be 5596 + 1130 = 6726[26]; which is approximately a gap in provision of 17%.
5) Thus, services are expecting to be unable to support a greater percentage of children and young people in 2015/2016 than the year previously.

6.3 Reflection and summary

The data presented in this final chapter illustrates the complexity involved in assessing need/ demand and capacity for service provision. The data also show that understanding 'capacity' is complex and can be interpreted in various ways. Capacity does not simply equate to the number of children and young people *actually* receiving a service. According to the way in which services responded about capacity, it also includes children and young people waiting for a service, sometimes for up to and over a year. Thus the use of waiting lists provides one explanation for why this gap may appear relatively small. It is important to also remember that the data are limited; the calculations above were only carried out using a small number of services. The picture may have been very different if more providers were able to provide the data we had asked for. There is, however, a clear gap in provision and what is more, some children and young people are waiting considerable periods to receive a service – regardless of what definition of 'capacity' is utilised.

Furthermore, evidence from the audit suggests that services are limiting and altering their provision in ways to cope with capacity; for example, hours of accessibility are very limited (see Chapter 5); respondents described having to reduce the number of sessions they provide; and services are imposing a range of eligibility criteria to reduce access to services. In other words, although some services may be able to see the same number of children and young people, they may be providing a reduced input which may minimize the impact and effectiveness of the service/ intervention.

We also considered that differences in eligibility criteria may provide an explanation for why services appear to have 'capacity'. It may be possible that strict eligibility criteria could divert children away from the service making it appear that a service has capacity. However, an examination of eligibility data by those services who expressly stated they have capacity versus those who did not did not support this hypothesis; no differences were found, for example, in either the number or type of criteria utilised between services 'with capacity' and 'without capacity'. It may be that the data is simply not sophisticated enough to identify the impact of eligibility criteria; and indeed, some services told us in open-ended questions that

[26] See Table 6b

commissioning requirements can determine who is eligible and who is not. Future research or audits should expand investigation into eligibility criteria in order to better understand the impact this has on provision.

A critical point to highlight is that there are many children and young people who experience abuse and who would benefit from support who may not actually come to the attention of services at all. The information from the mapping exercise suggests that some services reported having capacity or of operating waiting lists of three months. The qualitative data suggests that services may have evolved strategies to deal with the commissioning requirements so they can continue to see similar numbers of young people by operating waiting lists, or by reducing the length or frequency of contact. Given the broader evidence base, sense-checking of the findings with key stakeholders, and the methodological limitations outlined earlier in the report, it is useful to place these findings within the context of evidence on met and unmet need from other studies. For example, the London review of SARCs found that SARCs provided a service to just 192 children and young people under the age of 16 during 2013/2014, despite far more children and young people having experienced and reported assault to the police during that time (n=2485). Placing that in context with the NSPCC prevalence study, the authors calculated that 12,540 children 11 to 17 would have experienced contact sexual abuse in London during that time (Goddard et al., 2015). This data indicates that a majority of children and young people still do not report their abuse (or if they do, it may not be reported to the police or social care). Even those who do report their abuse to the Police do not always find their way to a SARC. The authors suggested that children and young people may be accessing other services such as Rape Crisis, sexual health clinics or Emergency Departments; but that it appears that children and young people may not be accessing the range of services available. Indeed, data on referral sources show that some important pathways for referral such as the Police are not well-developed.

7 Conclusion and recommendations

This mapping exercise was commissioned in order to understand the contemporary landscape of therapeutic provision for CSE and other forms of CSA. The evidence gathered through the study has enabled comment on the nature and shape of specialist and generalist services providing therapeutic support, the funding and commissioning experiences of these services, what forms of provision are available, accessibility of the services, data on current service use and finally, an exploration of met and unmet need among this sample of services. As such, it offers a significant contribution to an under-researched area of work. Key learning points within this include the following:

- Obtaining full and accurate data on current service use is complex and difficult, and the task has not improved since the 2007 audit where similar difficulties were encountered. A key recommendation in that report was an improvement in the recording of data, particularly by services such as Child and Adolescent Mental Health Services (CAMHs) but the evidence suggests this has not been addressed. This makes it incredibly difficult to establish solid evidence about the need/demand for services and whether or not current provision is adequately meeting the demand.
- Some of the generalist services in the current mapping exercise were unable to provide referral figures on CSA/CSE because they do not tend to disaggregate their figures on this particular issue.
- The referral data provided in the current mapping exercise shows an overall gap (a 12% current gap and an anticipated gap of 17% in future) in provision across the services in this sample to children and young people who have experienced child sexual abuse / exploitation. While some children may be referred to other services, there are likely to be some children who do not receive a service, or do not receive a timely service.
- The mapping exercise revealed a large number of services across the UK comprised of both specialist and generalist services which exist across statutory, voluntary and private sectors and in some case comprise multi-agency initiatives.
- Whilst specialist services have been identified by some commentators to be more responsive and tailored to victims of sexual violence, it is clear that in the current climate of increasing awareness and demand, generalist services are identifying and supporting children and young people who have experienced CSA / CSE.

- Despite variation in the needs and support required between younger children and older children who have experienced CSA/ CSE, some services are supporting both groups. What is less clear is whether these services are effectively equipped to provide specialised support to meet the needs of children and young people experiencing different forms of CSA.
- SARCs have been an important development in provision of streamlined support for victims of sexual violence, although a key finding identified both in the literature and within this mapping exercise is a lack of emotional support within these services for children and young people who have experienced child sexual abuse / exploitation.
- Since the 2007 audit, there appears to have been little change in the funding environment for CSA. Greater awareness of CSE means that it is possible that there has been more attention given to funding specialist services in this area at the expense of services dedicated to other forms of CSA.
- Across specialist services, funding continues to be provided through insecure and short-term funding cycles which are at odds with the nature of the provision required to adequately support children and young people with these experiences. Services continue to devote an enormous amount of time and energy to chasing new funding streams, which, they say diverts energy and time away from delivering quality services to children and young people.
- Service providers and commissioners have noted how complex and confusing the commissioning environment is, creating more stress and insecurity for providers.
- Service providers feel confident that they will continue to be funded but this confidence derives primarily from an optimism about their reputations and the current high priority of CSA/CSE rather than having actually secured future funding.
- Some referral sources for services are more developed than others; only 50% of services are seeing/accepting referrals from the police, for example and fewer from youth justice and youth services.
- CAMHs remain difficult to access and the situation appears to be declining in some areas in the face of funding cuts in recent years. Providers view CAMHs as largely difficult to access, a finding which has been identified in other studies and reviews of services.
- Almost all services, however, set eligibility criteria to restrict access. Age is one of the more common criteria and the mapping exercise has shown that, at least among the current sample, services for younger children are scarce while services for older children and adolescents are in somewhat greater supply.

- Although there is significant variability in the quality and amount of referral data received, the patterns of service provision suggest that it is White British girls without disabilities who comprise the largest group receiving services.
- Creative therapies remain a common approach in working with children and young people who have experienced sexual abuse. The 'therapeutic relationship' is also very common across services which focus on child sexual exploitation as well as other forms of child sexual abuse.
- Services are largely only accessible during the hours of 9 to 5 during the weekdays. For children and young people who may want and need support outside of these hours, provision is scarce.
- Children and young people with eating disorders, substance abuse problems, additional mental health needs and young offenders are most likely to be referred onwards to another service for help.

Although originally intended to facilitate comparative analysis with the 2007 audit, the fact that the 2015 and 2007 samples had negligible overlap (only two services participated in both studies) means this has not been possible. The inadvisability of direct comparison between the two studies is compounded by the different inclusion criteria (see Chapter Two) and the different datasets collated in each study. Some broad observations, can however, be offered on the findings of both studies. Patterns of referral by demographic data in 2015, though highly variable, do show similarities to the patterns observed in 2007. For example, more girls received services than boys; most children and young people who received services were White British; few had disabilities; more children age 10 to 15 received services than any other age group. Provision characteristics are also broadly similar between the two samples with creative therapies most common, followed by counselling and CBT. Social workers were the most common source of referral in both samples. Waiting lists, in both samples, were estimated by services to be three months on average although some services had waiting lists of up to and over a year. Respondents across both studies reported that they were operating within an insecure and short-term funding environment (with a greater number of services reporting an absence of indefinite funding in the current sample) which diverts energy away from the provision of quality services to children and young people.

Priority recommendations

There are three priority recommendations which have emerged from this mapping exercise. These can be summarised as 1) the need for better data on referrals; 2) the need for comprehensive support for children and young people; and 3) the need for a more stable and less complex commissioning and funding process.

4. **Recommendation 1:** The government should establish good and robust data on referrals for child sexual abuse. This could take the form of a central repository for referral data to be regularly submitted for the purposes of better understanding need and demand in the context of actual provision. All services (specialist and generalist) which support children and young people therapeutically should be recording CSA and CSE as a matter of course. In particular, generalist services should begin to record this information as it would assist in providing an accurate reflection of their work where they are encountering children and young people with these experiences. This would also enhance the national picture of demand experienced by services. Evidence from this mapping exercise, in concert with evidence from the 2007 audit, other research and consultation with experts suggest that CAMHs should also include classifications of sexual abuse in their initial assessments. This information should be recorded as a matter of course in order to improve assessment of need within the service, but also nationally.

5. **Recommendation 2:** Given the central government recognition of CSA/CSE as a 'national threat' and in the context of clearly evidenced increases in reporting, the government have a duty to ensure there is adequate provision for children and young people who have experienced sexual violence.

6. **Recommendation 3**: Government should look at ways of providing more secure funding for services delivering therapeutic support to children and young people who have experienced CSA (or are at risk of experiencing CSA). Doing so would ensure that these children and young people receive timely, adequate and un-interrupted therapeutic support to move on from their experiences. Funding bodies should look for ways of reducing the complexity and increasing the transparency of the commissioning and funding process. This would aid in reducing the workload and stress of already pressurised services and allow services to focus on the business of supporting children and young people.

Areas for further investigation

In addition to priority recommendations, there are a number of areas requiring further research and investigation, either because the limited nature of the current mapping exercise meant these areas could not be fully examined or because the mapping exercise revealed insights that raise further questions. These areas include the following:

I) While it is widely believed that specialist services are best placed to deliver specialist therapeutic support for victims of sexual violence, evidence from this mapping exercise suggests that generalist services are encountering children and young people who have experienced CSE and other forms of CSA. Not only that, but there is evidence to suggest they are now actively looking for these experiences given the high priority of CSA/CSE. Whether or not generalist services should be providing this support, the evidence is that they are. Specialist and generalist services, therefore, should have the right training and skills in place to deliver appropriate support. Further research is needed into the experiences of generalist services in identifying and supporting these children and young people.

J) Investigation is required into the best way to provide emotional support to children and young people who have experienced CSA/CSE. Given that SARCs are intended to provide a streamlined service for victims of sexual abuse / assault, it is important to further examine whether they should be providing emotional support as well or whether it is more appropriate for these services to refer children onwards.

K) Health, education and the police have a key role to play in identifying victims of violence and abuse, in providing early intervention for those at low and medium risk and in referring on to relevant specialist services. These agencies should identify and develop better links and relationships with all local, relevant support services.

L) More research is needed about provision for younger children experiencing intra-familial CSA. Adequate provision is required under international frameworks and at present, there appears to be greater attention aimed at services for older children.

M) More research is required to better understand why some service user groups continue to be under-represented in referrals to services and among those who receive services.

N) More research is required to establish a better evidence base for current approaches to working with children and young people who have experienced sexual abuse.

O) Service provision is largely delivered during office hours to children and young people. Further investigation is required as to why services are not offering support outside of these times, given that sexual violence can occur any time and that emotional support may be required at unconventional times.

P) While services report being able to work with children and young people who have a wide variety of needs, there are still some children with complex needs who require additional support. Further investigation is needed about

the ways in which services are doing this, in order to understand whether a gap exists for children with complex and particular needs.

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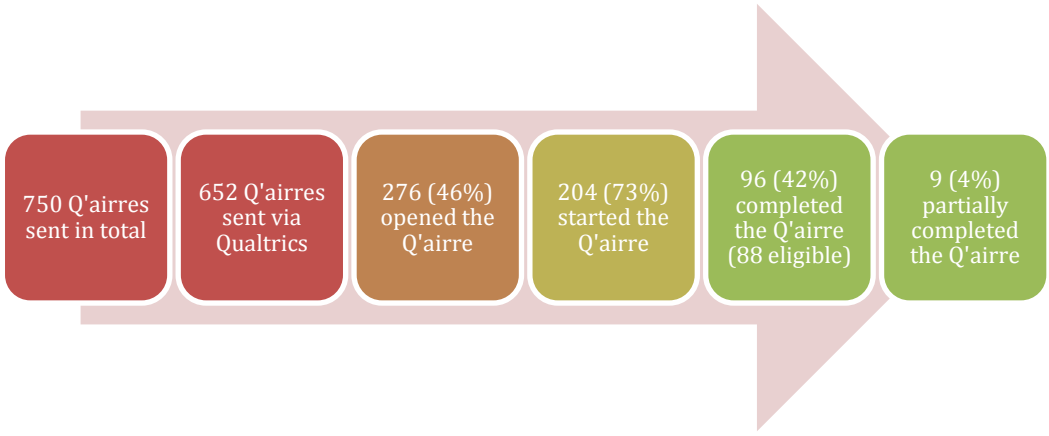
APPENDIX A – ADDITIONAL DETAIL ON THE RESPONSE RATE

The online questionnaire software has the ability to monitor and track receipt of questionnaires, the number who open questionnaires, the number who start questionnaires and the number who complete (and partially complete) questionnaires (where respondent email addresses have been uploaded to the software). Figure 2a provides an 'approximate' count of these stages. This is only approximate because over the course of data collection, direct contact with services via phone calls and emails continued and we estimate that around 50 to 60 contacts provided us with different email addresses to the original email we had recorded. They were then sent new links to the updated email address, but unfortunately, Qualtrics does not alter the overall count even if you have removed the original email address. Additionally, some services did not fill out links attached to Qualtrics because they were either a) sent links separately or b) they accessed links that were advertised on websites as described above. CAMH services particularly could not be effectively tracked because these services rarely advertise email addresses on the web. Most CAMH services were sent questionnaires by research or NSPCC staff individually after they confirmed details on the phone, which is why the overall count of the number of questionnaires distributed via Qualtrics falls well under 750 (the total number of services mapped).

Figure 1 Number of surveys sent, opened, started and partially completed via Qualtrics



Annexed Tables

2 Detailed data tables (Control-click on table title to return to the main text of the report)

Annex Table 2a: Country, by number (%) of generalist or specialist services

	England	N. Ireland	Scotland	Wales	Unknown country	Total within service type
Generalist	39 (34.8%)	2 (40%)	5 (27.8%)	2 (28.6%)	4 (57.1%)	52 (34.3%)
Specialist	73 (65.2%)	3 (60%)	13 (72.2%)	5 (71.4%)	3 (42.9%)	97 (65.7%)
Total within country	112 (100%)	5 (100%)	18 (100%)	7 (100%)	7 (100%)	149 (100%)

Annex Table 2b: Country, by number (%) of specialist service type

Type of service	England	N. Ireland	Scotland	Wales	Country not known	Total within specialist service type
CSA only	18 (25.4%)	0 (0%)	2 (16.7%)	2 (50%)	0 (0%)	22 (23.9%)
CSE only	12 (16.9%)	2 (66.7%)	3 (25%)	1 (25%)	1 (50%)	19 (20.7%)
CSA and CSE	41 (57.7%)	1 (33.3%)	7 (63.6%)	1 (25%)	1 (50%)	51 (55.4%)
Total within country	**71 (100%)**	**3 (100%)**	**12 (100%)**	**4 (100%)**	**2 (100%)**	**92 (100%)**

Annex Table 2c: Sector, by number of residential and non-residential services

Sector	Residential	Non-residential	Total
Statutory	2	18	20
Voluntary	5	112	117
Private	2	6	8
Part of a multiagency initiative	0	2	2
Total number of services	9	138	147

3 Detailed data tables

Annex Table 3a: Funding source, by sector (n=142)

Funding source	Statutory	Voluntary	Private	Multi-agency	Total
Vol/ Community sector (this can include organisations like Big Lottery or Comic Relief)	0	40	0	0	40
No main funder, multiple streams of funding	3	19	0	0	22
NHS	11	4	3	1	19
Social Care	4	10	5	0	19
Department of Justice	0	9	0	0	9
Police & Crime Commissioner	1	4	0	1	6
Education	0	1	0	0	1
Other	0	25	1	0	26
Total	**19**	**112**	**9**	**2**	**142**

Annex Table 3b: Current funding periods for services in each country

End of funding period	England	N. Ireland	Scotland	Wales	Country not known
2015	12 (11%)	2(40%)	4 (24%)	0 (0%)	0 (0%)
2016	42 (39%)	2 (40%)	7 (41%)	2 (29%)	1 (100%)
2017	8 (8%)	1 (20%)	1 (6%)	0 (0%)	0 (0%)
2018	4 (4%)	0 (0%)	1 (6%)	0 (0%)	0 (0%)
2019	2 (2%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
2020	3 (3%)	0 (0%)	0 (0%)	1 (14%)	0 (0%)
Other	16 (15%)	0 (0%)	1 (6%)	1 (14%)	0 (0%)
Indefinite	20 (19%)	0 (0%)	3 (18%)	3 (43%)	0 (0%)
Total within country	107 (100%)	5 (100%)	17 (100%)	7 (100%)	1 (100%)

Annex Table 3c: Current funding periods for services in each sector

End of funding period	Statutory	Voluntary	Private	Multiagency	Total
2015	2 (11%)	16 (15%)	-	-	18
2016	4 (22%)	47 (43%)	1 (13%)	2 (100%)	54
2017	-	9 (8%)	1 (13%)	-	10
2018	-	5 (5%)	-	-	5
2019	1 (6%)	1 (1%)	-	-	2

2020	-	4 (4%)	-	-	4
Other	-	16 (15%)	2 (25%)	-	18
Indefinite	11 (61%)	11 (10%)	4 (50%)	-	26
Total	18 (100%)	109 (100%)	8 (100%)	2 (100%)	137

Annex Table 3d: Level of confidence in funding by country

Level of confidence	England	N. Ireland	Scotland	Wales	Country not known	Total within level of confidence
Not at all	6 (7%)	0 (0%)	2 (13%)	0 (0%)	0 (0%)	8 (7%)
Quite unsure	11 (12%)	2 (40%)	2 (13%)	0 (0%)	0 (0%)	15 (12%)
Not sure	29 (31%)	1 (20%)	2 (13%)	1 (17%)	0 (0%)	33 (27%)
Quite confident	32 (34%)	0 (0%)	7 (44%)	3 (50%)	1 (100%)	43 (36%)
Very confident	15 (16%)	2 (40%)	3 (19%)	2 (33%)	0 (0%)	22 (18%)
Total within country	93 (100%)	5 (100%)	16 (100%)	6 (100%)	1 (100%)	121 (100%)

4 Detailed data tables

Annex Table 4a: Age criteria, by sector[a]

Age group	Statutory (n=17)	Voluntary (n=94)	Private (n=3)	Part of a multiagency initiative (n=2)
< 2 years	5 (29%)	6 (6%)	1 (33%)	2 (100%)
3-4	6 (35%)	14 (15%)	1 (33%)	2 (100%)
5-7	8 (47%)	43 (46%)	2 (67%)	2 (100%)
8-10	9 (53%)	44 (47%)	2 (67%)	2 (100%)
11-13	12 (71%)	66 (70%)	3 (100%)	2 (100%)
14-15	13 (76%)	76 (81%)	3 (100%)	2 (100%)
16-17	15 (88%)	85 (91%)	2 (67%)	2 (100%)

[a] The number of private sector and multi-agency services are so small that their inclusion here is solely for full transparency of data

Annex Table 4b: Age criteria, by generalist or specialist service

Age	Generic (n=40)	Specialist (n=76)
Under 2	6 (15%)	6 (8%)
3 to 4	8 (20%)	14 (18%)

5 to 7	21 (53%)	33 (43%)
8 to 10	21 (53%)	35 (46%)
11 to 13	30 (75%)	53 (70%)
14 to 15	32 (80%)	62 (82%)
16 to 17	35 (88%)	69 (91%)

Annex Table 4c: Age criteria, by type of specialist service

	CSA specialist services (n=19)	CSE specialist services (n=15)	CSA or CSE specialist services (n=38)
Under 2	1 (5%)	-	5 (13%)
3 to 4	5 (26%)	1 (7%)	8 (21%)
5 to 7	9 (42%)	1 (7%)	19 (50%)
8 to 10	11 (58%)	3 (20%)	19 (50%)
11 to 13	13 (68%)	12 (80%)	24 (63%)
14 to 15	14 (74%)	13 (87%)	31 (82%)
16 to 17	18 (95%)	12 (80%)	35 (92%)

Annex Table 4d: Length of time children and young people typically wait between being referred and receiving the service in each area, by nation[27]

Length of waiting list	England	Wales	N. Ireland	Scotland	Unknown	Total number of services
No waiting list	10	3	0	0	0	13
Up to 1 month	18	1	1	2	0	22
Up to 2 months	21	1	1	3	0	26
Up to 3 months	15	1	0	2	1	19
Up to 4 months	7	0	0	1	0	8
Up to 5 months	1	0	0	1	0	2
Up to 6 months	5	0	0	1	0	6
Up to 9 months	3	0	1	1	0	5
Up to 10 months	0	0	0	0	1	1
Up to 12 months	2	0	0	0	0	2
Over a year	1	0	0	0	0	1
Currently service	19	0	1	4	0	24

[27] Percentages have not been calculated because of the very small number of services across nations and categories

has capacity						

Annex Table 4e: Capacity, by generic or specialist services

Length of waiting list	Generic	Specialised	Total
Does not operate waiting lists	2	11	13
Up to 1 month	7	13	20
Up to 2 months	4	22	26
Up to 3 months	9	10	19
Up to 4 months	1	7	8
Up to 5 months	0	2	2
Up to 6 months	1	4	5
Up to 9 months	3	2	5
Up to 10 months	1	0	1
Up to 12 months	1	1	2
Over a year	0	1	1
Currently service has capacity	11	13	24
Total	40	86	126

Annex Table 4f: Number of services by country which reported being able to provide information on referral rates and characteristics (and percentage of services within each country)

Ability to provide referral information	England	N. Ireland	Scotland	Wales	Country not known	Total
Yes	70 (67.3%)	3 (60%)	11 (73.3%)	4 (66.7%)	2 (100%)	90 (68.2%)
No	34 (32.7%)	2 (40%)	4 (26.7%)	2 (33.3%)	0 (0%)	42 (31.8%)
Total	104 (100%)	5 (100%)	15 (100%)	6 (100%)	2 (100%)	132 (100%)

Annex Table 4g: Total number of children and young people accepted after referral in different areas of the UK

Country	England	N. Ireland	Scotland	Wales	Country not known	Total
Number of services providing data	65	3	11	4	1	84
Total places	4462	179	888	147	57	5733

Annex Table 4h: Total number of referrals by gender, minimum/maximum number of referrals and average/median number of referrals, by all services (generalist and specialist combined) and by specialist only

Gender	Total Number (%)	Minimum / maximum number of referrals	Average and median number of referrals

	All services	Specialist only	All services	Specialist Only	All services	Specialist only
Girls (n=46)	2942 (72.2%)	2835 (74.4%)	1/ 200	1/200	49.03 (36.5)	56.29 (39.0)
No. services	60	45				
Boys (n=45)	1126 (27.7%)	973 (25.5%)	0/ 170	0/ 170	19.08 (12.0)	19.64 (12.0)
No. services	59	44				
Unknown gender (n=4)	4 (<0%)	2 (<1%)	0/ 2	0/ 2	<1 (0.0)	.50 (0.0)
No. services	6	4				
Total places	4072 (100%)	3810 (100%)				

Annex Table 4i: Total number of referrals by age group, minimum/maximum number of referrals and average/median number of referrals, by all services (generalist and specialist combined) and by specialist only

	Total Number (%)		Minimum / maximum number of referrals		Average and median number of referrals	
Age group	**All services**	**Specialist only**	**All services**	**Specialist Only**	**All services**	**Specialist only**
Age up to 9 inclusive	380 (18.9%)	212 (13.9%)	0/ 65	0/ 41	12.67 (5.50)	10.60 (5.0)
No. services	30	20				
Age 10 to 15	1007 (50.0%)	783 (51.3%)	0/ 95	0/ 95	24.56 (15.0)	26.10 (15.0)
No. services	41	30				
Age 16 to 17	630 (31.1%)	531 (34.8%)	1/ 74	1/ 74	14.65 (12.0)	17.13 (12.0)
No. services	43	31				
Total	2017 (100%)	1526 (100%)				

Annex Table 4j: Total number of referrals by ethnicity, minimum/maximum number of referrals and average/median number of referrals, by all services (generalist and specialist combined) and by specialist only

Ethnicity	Total Number (%)		Minimum / maximum number of referrals		Average and median number of referrals	
	All services	Specialist only	All services	Specialist Only	All services	Specialist only
White British	1814 (32.4%)	1122 (13.8%)	2/ 216	2/164	44.24 (30.0)	38.69 (30.0)
No. services	41	29				
White Irish	34	11	0/ 10	0/ 4	2.27 (1.0)	1.10 (.50)
No. services	15	10				
Other White	138	60	0/ 64	0/ 31	6.57 (2.5)	4.29 (2.50)
No. services	21	14				
Mixed background	158 (45.5%)	69 (51.2%)	0/ 72	0/ 15	6.87 (2.0)	4.60 (2.0)
No. services	23	15				
Asian or Asian British	167 (22.0%)	98 (34.9%)	0/ 39	0/ 37	7.59 (2.0)	7.0 (2.0)
No. services	22	14				
Black or Black British	270 (100%)	63 (100%)	0/ 182	0/ 23	10.80 (3.0)	3.94 (2.50)
No. services	25	16				
Chinese or other ethnic group	16	6	0/ 4	0/ 3	1.07 (1.0)	.67 (0.0)
No. services	15	9				
Other ethnicity	458	159	0/ 298	0/ 77	28.63 (2.0)	11.36 (2.0)
No. services	16	14				

5 Detailed data tables

Annex Table 5a: Additional approaches delivered in services

Eco-therapy Brief intervention Motivational interviewing Dialectical behavioural therapy EMDR Feminist Inner child Integrated Good lives and good way approach Theraplay Dyadic development psychotherapy	Trauma-focussed CBT Bespoke service trauma models Mentalisation Mindfulness Solution-focussed brief intervention Hypnotherapy Person-centred Systemic Somatic/body work Humanistic

6 Detailed data tables

Annex Table 6a: Number of children and young people who did not receive help last year, by country

Reason	England	Wales	N. Ireland	Scotland	Unknown location	Total no. children
Service lacked expertise to support client	214 (11 services)	-	-	-	34 (1 service)	248
Service lacked capacity to provide a service to the client	261 (20 services)	12 (2 services)	7 (1 service)	-	73 (1 service)	353
Service was unable to provide a service to the client for another reason	289 (13 services)	-	-	30 (1 service)	3 (2 service)	322

Annex Table 6b: Number of young people who did not receive help last year and reasons why provided by services, by sector

Sector	Lack of expertise	Lack of capacity	Other reason
Statutory	27 young people (1 service)	15 young people (1 service)	14 young people (2 services)
Voluntary	221 young people (7 services)	329 young people (22 services)	301 young people (11 services)
Private	-	9 young people (2 services)	4 young people (1 service)
Multiagency	-	-	5 young people (1 service)

Annex Table 6c: Number of young people who did not receive help last year, and reasons why, by service type

Sector	Lack of expertise	Lack of capacity	Other reason
Generic	225 young people (5 services)	219 young people (11 services)	206 young people (8 services)
Specialised	23 young people (7 services)	134 young people (14 services)	118 young people (8 services)
Total	248 young people	353 young people	324 young people

Annex Table 6d: Likelihood that services will have to stop taking referrals over the next 12 months

	England	Wales	N. Ireland	Scotland	Unknown	Total number of services
Very unlikely	37 (35.2%)	1 (25%)	1 (33.3%)	6 (40%)	0 (0%)	45 (35.2%)
Unlikely	39 (37.1%)	2(50%)	2 (66.7%)	6 (40%)	1 (100%)	50 (39.1%)
Likely	22 (21%)	1(25%)	0 (0%)	2 (13.3%)	0 (0%)	25 (19.5%)
Very Likely	7 (6.7%)	0 (0%)	0 (0%)	1 (6.7%)	0 (0%)	8 (6.3%)
Total number of services	105 (100%)	4 (100%)	3 (100%)	15 (100%)	1 (100%)	128 (100%)

Annex Table 6e: Number of services by sector cross-referenced with how likely they anticipate having to stop taking referrals over the next 12 months

Sector	Very Unlikely	Unlikely	Likely	Very likely	Total

Statutory	10 (55.6%)	6 (33.3%)	2 (11.1%)	0 (0%)	18 (100%)
Voluntary	28 (27.5%)	43 (42.2%)	23 (22.5%)	8 (7.8%)	102 (100%)
Private	6 (100%)	0	0	0 (0%)	0 (100%)
Multi	1 (50%)	1 (50%)	0	0	2 (100%)
Total	45 (35.2%)	50 (39.1%)	25 (19.5%)	8 (6.3%)	128 (100%)

Annex Table 6f: Numbers of children and young people that services estimate they will able to provide a service to over the next 12 months

	England	**Wales**	**N. Ireland**	**Scotland**	**Unknown**	**Total**
Number of anticipated cases services will be able to support	4542	131	147	687	89	5596
Number of services which provided estimates	67	4	3	10	2	86

Annex Table 6g: Anticipated levels of service provision that can be provided next year by Sector

	Statutory	**Voluntary**	**Private**	**Multi-agency**	**Total**
Number of anticipated cases services will be able to support	569	4676	149	202	5,569
Number of services which provided estimates	8	72	4	2	86

Table 6h: Services' estimation of how many children and young people they would be *unable* to provide their service to over the next 12 months

	England	**Wales**	**N. Ireland**	**Scotland**	**Total**
Services' estimation of the number of cases which they will not be able to support	998	73	18	41	1130
Number of services which said they would not be able to meet anticipated need	40	4	3	4	51
Number of services which said they would be able to meet all need	17	0	0	6	23

Table 6i: Anticipated levels of service provision that cannot be provided next year

	Statutory	Voluntary	Private	Multi-agency	Total
Number of anticipated cases services will be able to support	30	1030	70	--	1130
Number of services which provided estimates	3	45	3	--	51